Hepatitis C programs
by organisations providing harm reduction services in Europe
Disclosures

- The good practice collection was partly funded by Gilead Science
• Thematic focus (HCV, NDDP, ODP)

Network
Creates framework and structure

Monitoring
Creates knowledge

Advocacy
Translate findings into advocacy messages

Capacity Building
Translates + summarise findings into practice

• Thematic focus (HCV, NDDP, ODP)
AIM OF THE PROJECT

To identify and select good practice examples in the field of HCV awareness, testing, access to treatment and care for PWUD in harm reduction and community settings in the European region and to offer service providers, social and health professionals and policy makers relevant information with which to encourage the development of new HCV interventions for PWUD, or to improve existing ones.

TWO PHASES

1. Data collection through an exploratory survey among civil society organisations providing harm reduction services & evaluation process
2. In-depth study of the selected Good Practices
Fig. 1 – Number of applicant organizations according to particular types of services they provide (N=60)

Fig. 2 – Geographic distribution of selected applications (N=60) from 27 countries.
Fig. 3 – Number of applicant organizations according to particular types of services they provide (N=60)

- Paraphernalia distribution: 48
- Needle & syringe distribution: 45
- Low-threshold drug services & counselling: 44
- Outreach: 39
- Street work: 33
- Others: 29
- Mobile unit: 24
- Opioid substitution treatment: 21
- Prison work: 14
- Drug Consumption Room: 10
- Shelter: 8

Fig. 4 – Number of applicant organizations according to particular staff implementing hepatitis C interventions (N=60)

- Social workers: 68
- Nurses: 44
- Others: 43
- Medical doctors: 29
- Hepatologists: 29
- Peer workers (volunteers): 29
- Peer workers (staff): 20
- Hepatitis reference nurse: 9

Fig. 5 – Number of applicant organizations according to particular staff implementing hepatitis C interventions (N=60)

- PWID: 60
- PWID: 59
- People experiencing homelessness: 34
- Sex workers: 27
- Young people at risk: 26
- MSM: 15
- Documented migrants: 10
- Undocumented migrants: 15
- Other: 12
Fig. 6 ~ Number of applicant organizations according to the HCV information methods implemented for staff (N=60)

- Handed out information material: 45
- Team meetings to discuss new information/treatments: 45
- Hiring Hep. ambassador: 7
- Internal/external education: 43

Fig. 7 ~ Number of applicant organizations according to the HCV information methods implemented for clients (N=60)

- Providing counseling: 56
- Collecting Hep. related data (intake/counseling): 52
- Internal/external education: 38
- Internal/external education (Other): 36
- Other: 7
### Fig. 12 – Number of applicant organizations according to the type of support offered for clients with an active HCV infection* (N=55)

<table>
<thead>
<tr>
<th>Service Provided</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offering treatment externally</td>
<td>35</td>
</tr>
<tr>
<td>We don't offer any HCV support, but refer externally</td>
<td>21</td>
</tr>
<tr>
<td>Disease self-management control</td>
<td>20</td>
</tr>
<tr>
<td>Liver health monitoring / assessment</td>
<td>20</td>
</tr>
<tr>
<td>Offering HCV treatment onsite</td>
<td>13</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
</tr>
<tr>
<td>We don't offer any support, and can't refer externally</td>
<td>2</td>
</tr>
</tbody>
</table>

* positive HCV Ag and/or HCV-FIA test result

### Fig. 13 – Number of applicant organizations according to typology of staff acting as a contact point in case of referral (N=58)

<table>
<thead>
<tr>
<th>Staff Typology</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatology / Infectology service at hospital</td>
<td>37</td>
</tr>
<tr>
<td>Individual hepatologist / infectious disease specialist</td>
<td>13</td>
</tr>
<tr>
<td>Others</td>
<td>7</td>
</tr>
<tr>
<td>Individual GP</td>
<td>3</td>
</tr>
<tr>
<td>Municipal health service</td>
<td>3</td>
</tr>
</tbody>
</table>

### Fig. 14 – Number of applicant organizations according to level of integration within the cascade of care in their city/region (N=58)

<table>
<thead>
<tr>
<th>Level of Integration</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>My organization is integrated within the cascade of care</td>
<td>25</td>
</tr>
<tr>
<td>My organization has a signed referral agreement with a hospital or medical facility</td>
<td>13</td>
</tr>
<tr>
<td>My organization struggles to be integrated within the cascade of care</td>
<td>10</td>
</tr>
<tr>
<td>none of the above</td>
<td>10</td>
</tr>
</tbody>
</table>
Fig. 15 – Number of applicant organizations according to self-identified needs to (continue) providing HCV services (N=60)

- More funding for equipment and services: 35
- Attitude of medical sector has to change towards providing services to PWID: 30
- Attitude of medical sector has to change towards harm reduction services/approach: 26
- More opportunities to hire, train and support peer workers: 24
- Change in national treatment guidelines to encourage HCV testing and/or treatment for PWID: 23
- Change in national level policies to facilitate reimbursement for our clients: 23
- More staff: 22
- More educational materials: 21
- More staff training: 18
- Specific approvals to provide services in our site: 17
- More educational and training materials for staff: 15

Fig. 16 – Number of applicant organizations according to their self-identified capacity to deliver HCV services (N=60)

- My organization is equipped to deliver comprehensive HCV services but we need additional resources to meet the requirements/existing demand: 32
- My organization can support HCV services any further as it is not within our formal purpose: 11
- My organization is fully equipped to deliver comprehensive HCV services matching the current requirements, and doesn’t need additional resources: 14
The majority of Organisations are equipped to deliver comprehensive HCV services. Agencies have reported having widely implemented HCV information systems, prevention and control activities. However, only one-in-four organisations can support on-site HCV treatment and chronic care & more than half reported needing additional resources to meet the existing service demands.

Harm reduction and community-based services are still not fully integrated within the cascade of care. The structural barriers that hinder an effective linking of PWUD to health services are of a legal, regulatory and policy nature, and the lack of safer institutional environments in which stigma and discrimination against PWUD and/or harm reduction approaches are discouraged.

Peer involvement is not yet commonplace. Less than half of the organisations count peers as paid workers in their teams and less than half count peers as volunteers. A similar situation exists with regards to counselling, with only a third of organisations involving peers in this activity.

Data provided by respondents presents a reality in which harm reduction and community-based programmes lack dedicated budgets or financial programmes for the development and implementation of HCV interventions for PWUD.
RECOMMENDATIONS

1. **Remove legal, regulatory and/or policy barriers** that hinder equitable access to hepatitis services, especially for most-affected populations and other groups at risk, such as PWUD.

2. **End policies and practices** that reproduce, or encourage, **discrimination** and **stigma** against PWUD in health and social care settings and towards harm reduction in general.

3. Provide **more hepatitis C-related programme funding**

4. Develop **national norms, quality standards** and certification for HCV testing and treatment in community and harm reduction settings.

5. **Improve data collection capacity** and its analysis by harm reduction and community-based services.

6. **Actively engage PWUD and HCV-affected populations** in developing, implementing and evaluating strategies and programmes.

7. Provide **more opportunities for the training of staff**, including peers and target groups as well as the development of updated educational materials.
Good practice examples of hepatitis C interventions by organisations providing harm reduction services in Europe