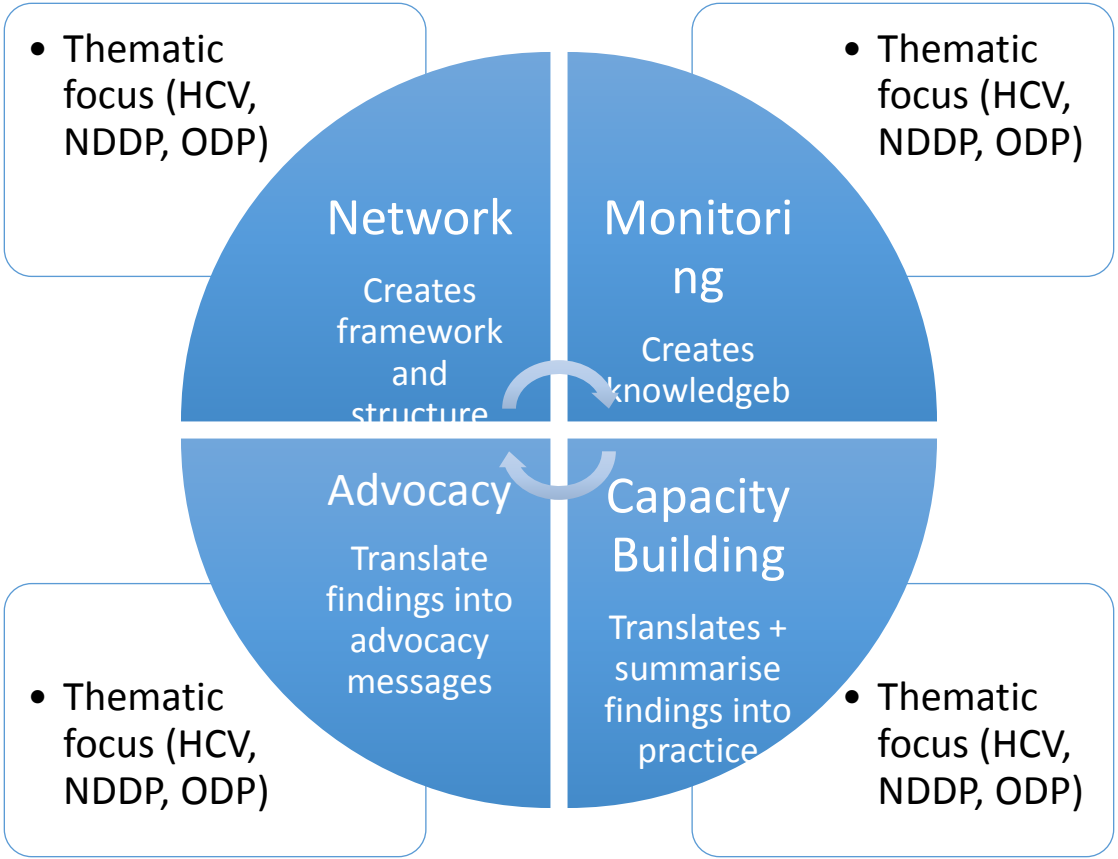
Hepatitis C programs

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
• Thematic focus (HCV, NDDP, ODP)
Monitoring
Creates knowledgeb
Advocacy
Translate findings into advocacy messages
• Thematic focus (HCV, NDDP, ODP)
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

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Fig. 1 ~ Number of applicant organizations according to particular types of services they provide (N=60)

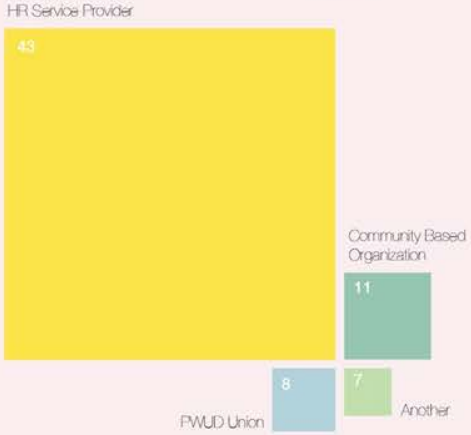

Fig. 2 ~ Geographic distribution of selected applications (N=60) from 27countries.

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Fig. 3 ~ Number of applicant organizations according to particular types of services they provide (N=60)

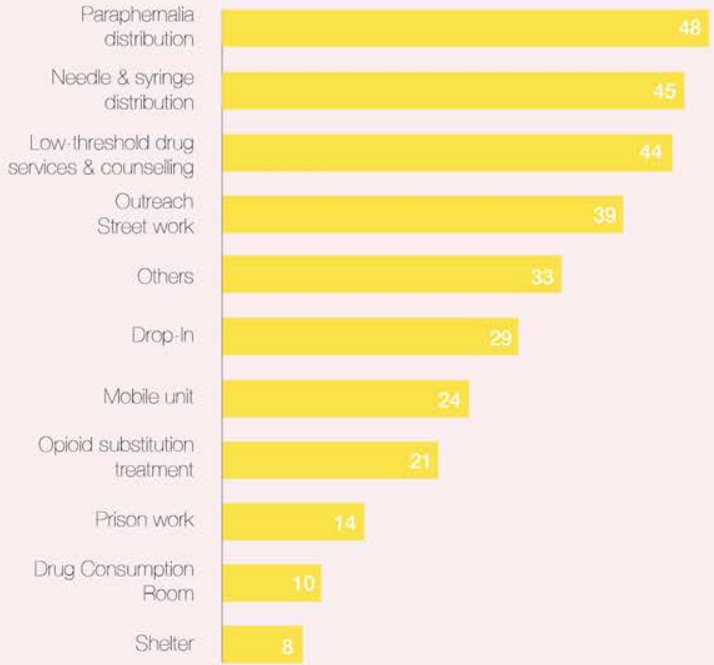

Fig. 4 ~ Number of applicant organizations according to particular staff implementing hepatitis C interventions (N=60)

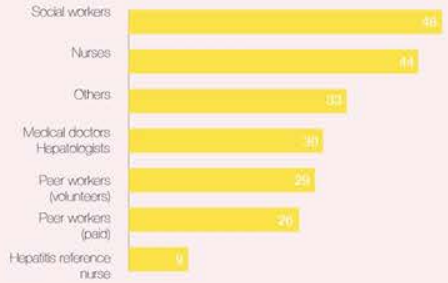

Fig. 5 ~ Number of applicant organizations according to particular staff implementing hepatitis C interventions (N=60)

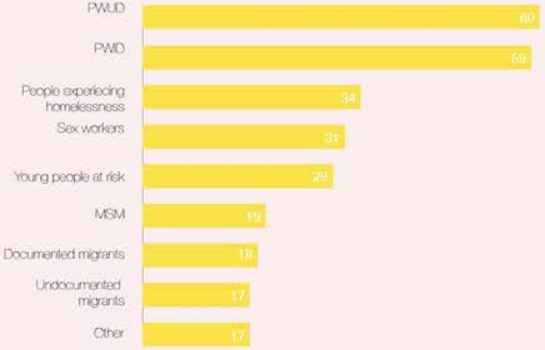

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Fig. 6 ~ Number of applicant organizations according to the HCV information methods implemented for staff (N=60)

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

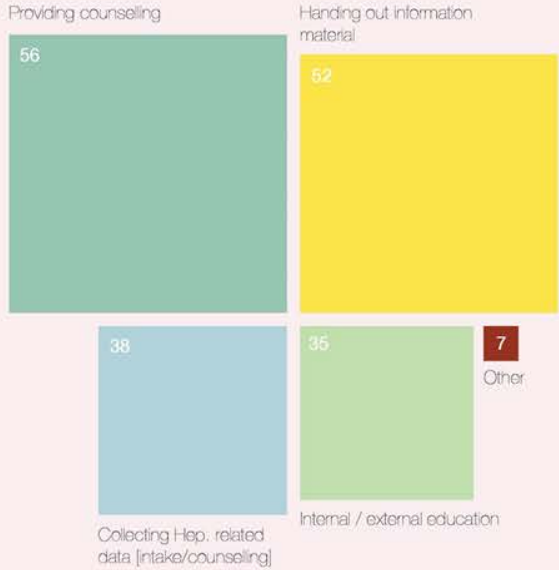

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Fig. 12 ~ Number of applicant organizations according to the type of support offered for clients with an active HCV infection* (N=55)

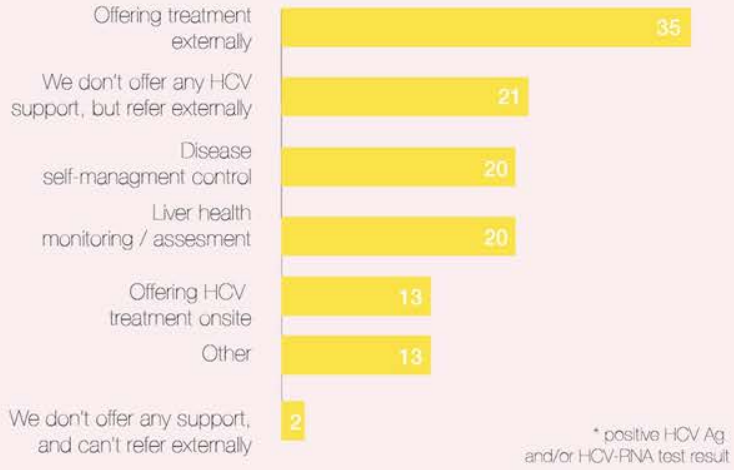

Fig. 13 ~ Number of applicant organizations according to typology of staff acting as a contact point in case of referal (N=59)

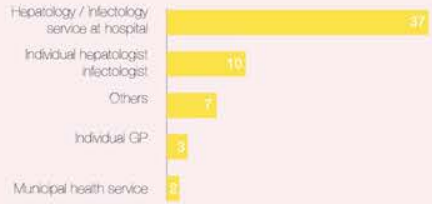

Fig. 14 ~ Number of applicant organizations according to level of integration within the cascade of care in their city/region (N=58)

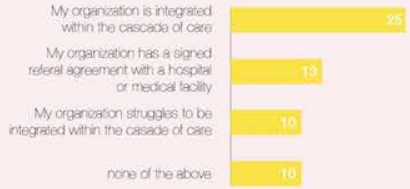

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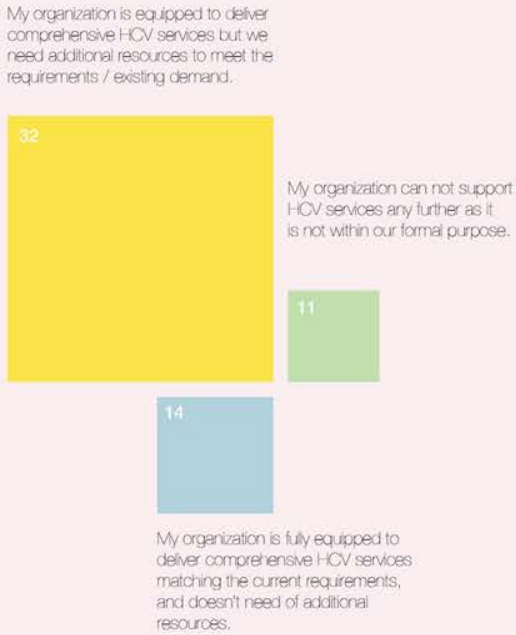
Fig. 15 ~ Number of applicant organizations according to self-identified needs to (continue) providing HCV services (N=60)

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



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READINESS TO RESPOND TO HCV

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

CONTINUUM OF CARE

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.

COMMUNITY INVOLVEMENT

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.

FINANCIAL STABILITY

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

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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 a 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.

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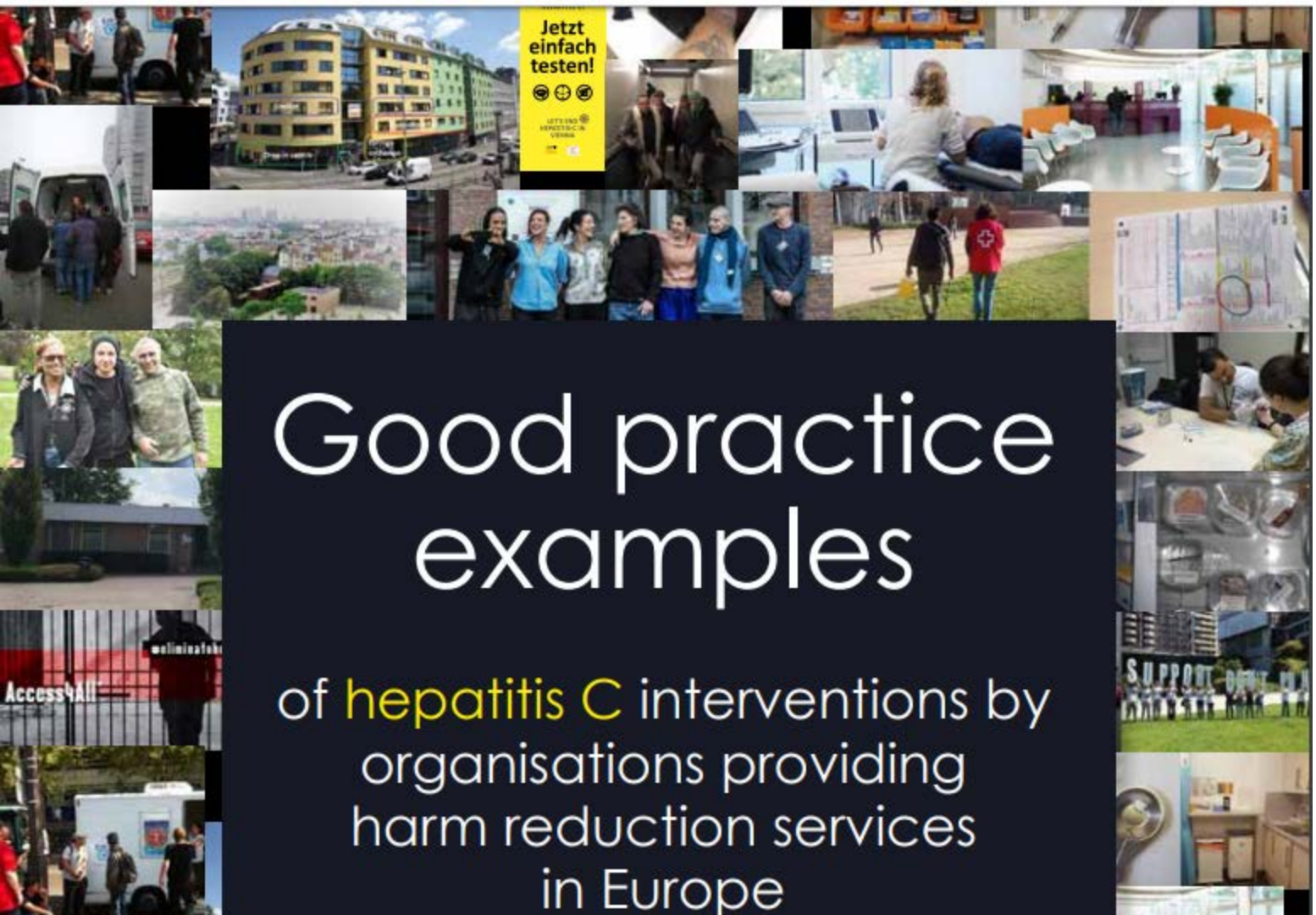

Good practice examples

of hepatitis C interventions by organisations providing harm reduction services in Europe