Eliminating Hepatitis C in Europe

Report on Policy Implementation for People Who Inject Drugs

Civil Society Monitoring of Harm Reduction in Europe **2023**

Correlation
European Harm Reduction Network

BOOST

Title

Eliminating Hepatitis C in Europe: A Report on Policy Implementation for People Who Inject Drugs. Civil Society Monitoring of Harm Reduction in Europe 2023.

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Contents

Acronyms

C-EHRN	Correlation - European Harm Reduction Network
COVID	Coronavirus Disease
CSO	Civil Society Organisation
DAA	Direct Acting Antiviral
EASL	European Association for the Study of the Liver
ECDC	European Centre for Disease Prevention and Control
EEA	European Economic Area
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
FP	Focal Point
GP	General Practitioner
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
MDT	Multi-Disciplinary Team
NHS-E	National Health Service - England
OAT	Opioid Agonist Treatment
OST	Opioid Substitution Treatment
PCR	Polymerase Chain Reaction
RKI	Robert Koch Institute
STI	Sexually Transmitted Infection
WHO	World Health Organization

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Introduction & Methodology

Introduction

WHO's global hepatitis strategy, endorsed by all WHO Member States, aims to reduce new hepatitis C virus (HCV) infections by 90% and HCV-related deaths by 65% between 2016 and 2030[1]. According to the latest surveillance report (ECDC 2022[2]), a total of 14,560 newly diagnosed cases of hepatitis C were documented across 29 EU/EEA Member States in 2021. Among these cases, the most common mode of transmission was injecting drug use. However, the nature of the infection, which is often asymptomatic until in advanced stages, complicates surveillance efforts as the data often reflects testing patterns rather than the underlying epidemiology and the burden of the disease.

There is a necessity for tailored surveillance and coordinated responses including public health programmes and harm reduction strategies that address the specific epidemiological patterns within each local context. To achieve WHO's HCV elimination goal by 2030, a continuum-of-care for people who inject drugs must be implemented and monitored.

1. World Health Organization. Hepatitis. Geneva; WHO. https://www.who.int/health-topics/hepatitis/elimination-of-hepatitis-by-2030#tab=tab_1
2. European Centre for Disease Prevention and Control. Hepatitis C. In: ECDC. Annual epidemiological report for 2021. Stockholm: ECDC; 2022. https://www.ecdc.europa.eu/sites/default/files/documents/AER-HEP-C-2021.pdf

Methodology

In the spring of 2023, for the fifth year in a row, C-EHRN invited civil society organisations (CSOs) from European countries to complete a 25-item online survey, with both single, multiple-choice and open-ended questions, on the availability of, and access to, interventions that constitute the HCV continuum-of-care specific for people who inject drugs. Consequently, this section consists of four parts: 1) the use and impact of national strategies and guidelines on accessibility to HCV testing and treatment for people who inject drugs; 2) the functioning of the continuum-of-care in different countries and cities; 3) potential changes in the continuum of services compared to the previous year; and, 4) the role of harm reduction services and organisations in this context.

The survey respondents are designated as focal points (FPs) within the Correlation – European Harm Reduction Network (C-EHRN FPs). FPs serve as national reference points for gathering data and information pertaining to a wide range of harm reduction-related issues. C-EHRN, a European civil society network operating in the realm of drug use and harm reduction, encompasses a diverse spectrum of participants, including grassroots and community-based organisations, service providers, drug user organisations, and research organisations. The network boasts a total of 314 members, being 176 organisational and 188 individual members, with 40 FPs among the organisational members at the time of the survey. Over 70% of FP organisations primarily focus on delivering harm reduction services. This fact underscores their significance as a valuable source for gaining insights into the practical implementation of these services. Additionally, other key areas of focus among the FPs includes advocacy and policy initiatives, and training and capacity building.

The focus of different survey questions varies between the national level situation and the city level situation; the focus being mainly at city level. During the 2020-2023 observational period, there are differences in responding FPs among particular years. For some of the questions that have been answered each year by the same respondents, a comparison of responses has been made over the study period 2020-2023 to observe the possible development achievements.

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Results

Map 1: C-EHRN Focal Points location & contribution years.

For 2023, the 40 C-EHRN FPs were invited to respond to the survey, and 35 of them did so, representing 35 cities and 32 countries: Amsterdam, Antwerp, Athens and Thessaloniki[3], Balti, Barcelona, Berlin, Bern, Bielefeld, Bratislava, Budapest, Copenhagen, Dublin, Glasgow, Helsinki, Iceland[4], Krakow, Kyiv, Ljubljana, London, Luxembourg, Malta, Milan, Newport, Nicosia, Paris, Podgorica, Porto, Prague, Rome, Sofia, Stockholm, Tallinn, Tirana, Vienna, and Warsaw (See Map 1 and Annex 1).

There are two cities from Germany (Berlin and Bielefeld), Italy (Milan and Rome) and Poland (Krakow and Warsaw). There are altogether three cities in the UK (London, Glasgow, Newport) but for the national-level questions Glasgow's answers cover only Scotland, Newport's answers cover only Wales, and London's answers cover only England, not the whole of the UK. For Albania, the answers apply to a total of nine cities[5], although the reporting mentions only one, Tirana, for the sake of consistency.

About half of the respondents (17/35, 48.6%) had consulted external experts for their answers on HCV policy and practices. In the category 'other', the two consulted experts in Copenhagen and Berlin were people with lived experience (Figure 1).

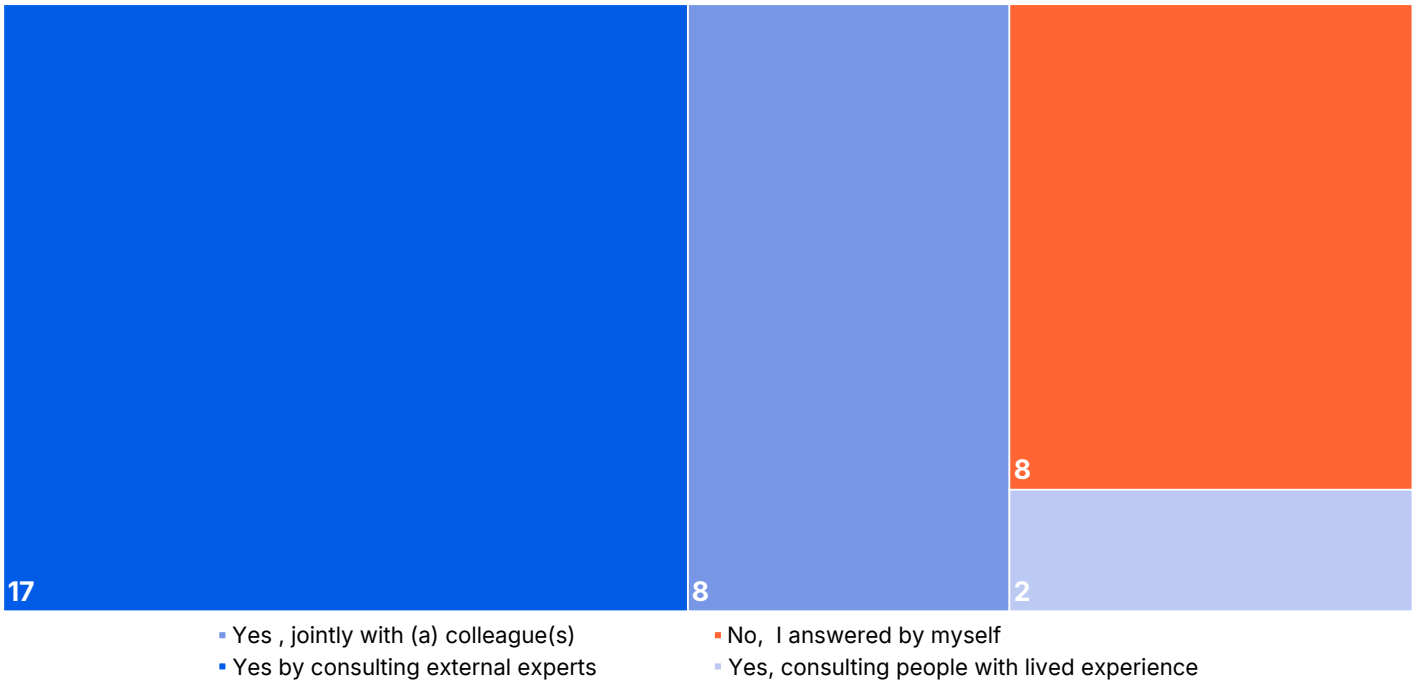


Figure 1. Were the answers given in this section (HCV) consulted with other experts? **(n=35)**

3. Together as one respondent.
4. The answers from Iceland and Malta, as two small islands, cover the whole country, not only one city.
5. Tirana, Shkoder, Durres, Elbasan, Berat, Fier, Vlore, Korce and Sarande.

National guidelines and real-life practices

A set of international and national guidelines have been created to assist work processes developed in the field of hepatitis. The first part of the C-EHRN monitoring survey assesses the use and impact of national or international guidelines on accessibility to testing and treatment for people who inject drugs from the viewpoint of harm reduction service providers[6].

The responses were given at country level (n=32). All but two FPs reported using either their own national guidelines (14/32, 40.0%), EASL guidelines (7/32, 20.0%), separate national guidelines for people who inject drugs (4/32, 14.3%), or other guidelines (3/32, 11.4%) such as WHO guidelines that encompass individuals who inject drugs. Respondents from two countries (2/32, 5.7%), Bulgaria and Poland[7], stated that they lack any HCV guidelines pertaining to people who inject drugs (Figure 2; Table 1).

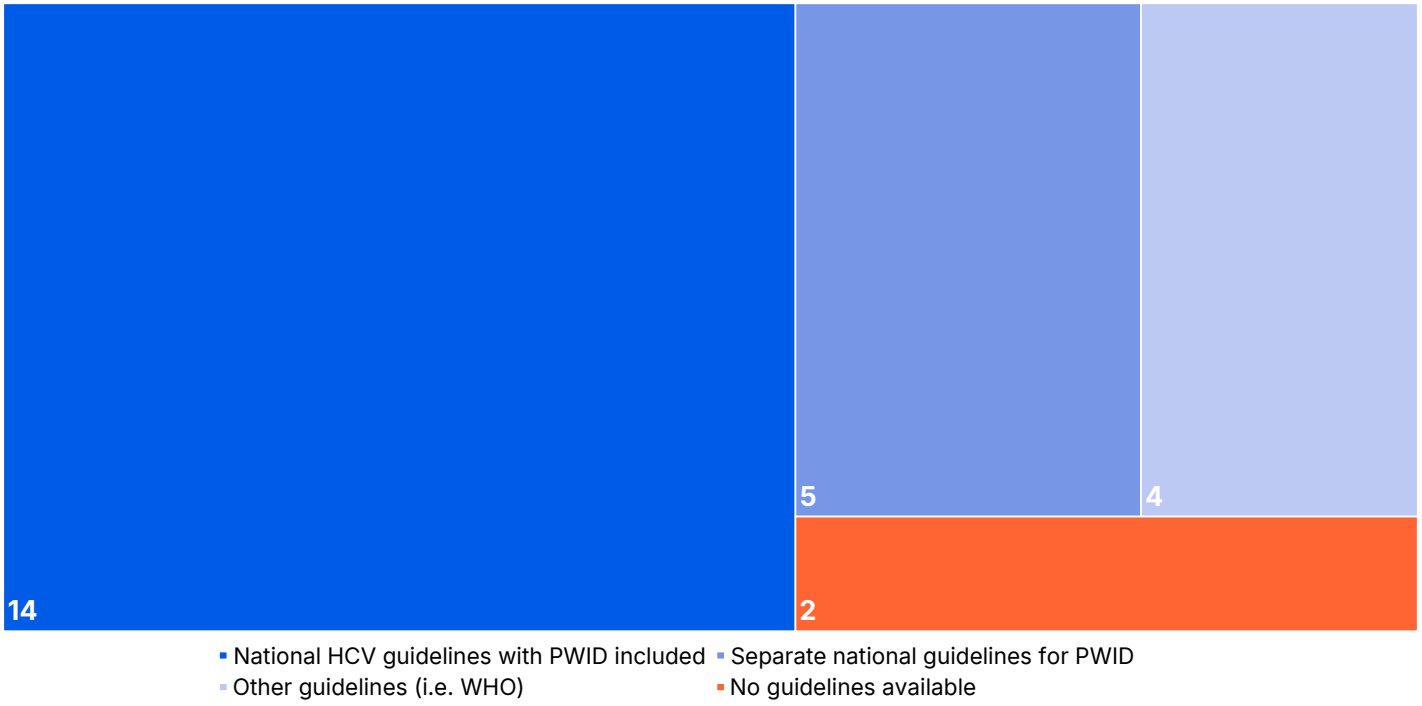


Figure 2. Which guidelines for HCV testing and treatment of people who inject drugs are used in your country? **(n=32)**

6. Both the WHO and ECDC together with the EMCDDA have recently updated their guidelines. The WHO's, "New recommendation on hepatitis C virus testing and treatment for people at ongoing risk of infection: policy brief", can be found at https://apps.who.int › rest › bitstreams › retrieve and a document for the update of the joint ECDC and EMCDDA guidelines, 'Prevention and control of infectious diseases among people who inject drugs' (2023), can be found at https://www.ecdc.europa.eu/sites/default/files/documents/Summary-Expert-Panel-discussions-among-PWID-JD-FINAL.pdf
7. In Poland, there are no guidelines but there are, however, recommendations from the Polish association for the study of the liver. In the newest recommendations from 2023 onwards, exclusion of people who use drugs from treatment is no longer recommended.

National guidelines that include people who inject drugs (n=14)	EASL guidelines (n=7)	Separate national guidelines for people who inject drugs (n=5)	Other guidelines (i.e. WHO) (n=4)	No guidelines (n=2)
Albania Czechia Denmark Finland France Germany Greece Hungary Luxembourg Moldova Montenegro Sweden Ukraine Wales	Belgium Cyprus England Estonia Ireland Italy Malta	Netherlands Portugal Slovenia Spain Switzerland	Austria Iceland Scotland Slovakia	Bulgaria Poland

Table 1. Which guidelines are used in different countries (n=32)

Even if guidelines exist, they might have limited impact in practice. Respondents were further asked to assess how these guidelines impact access to HCV testing, treatment and other services for people who inject drugs in their city.

Overall, respondents from 27 cities (27/35, 77.1%) thought the guidelines had a positive impact. All of them (27/35, 77.1%) mentioned better access to treatment, and 25/32 (71.4%) of respondents also mentioned a positive impact on access to testing. Many also felt that the guidelines improved access to integrated HCV, human immunodeficiency virus (HIV) and sexually transmitted infections (STI) services (18/35, 51.4% of all) as well as to civil society-based services (16/35, 45.7%) (Figure 3).

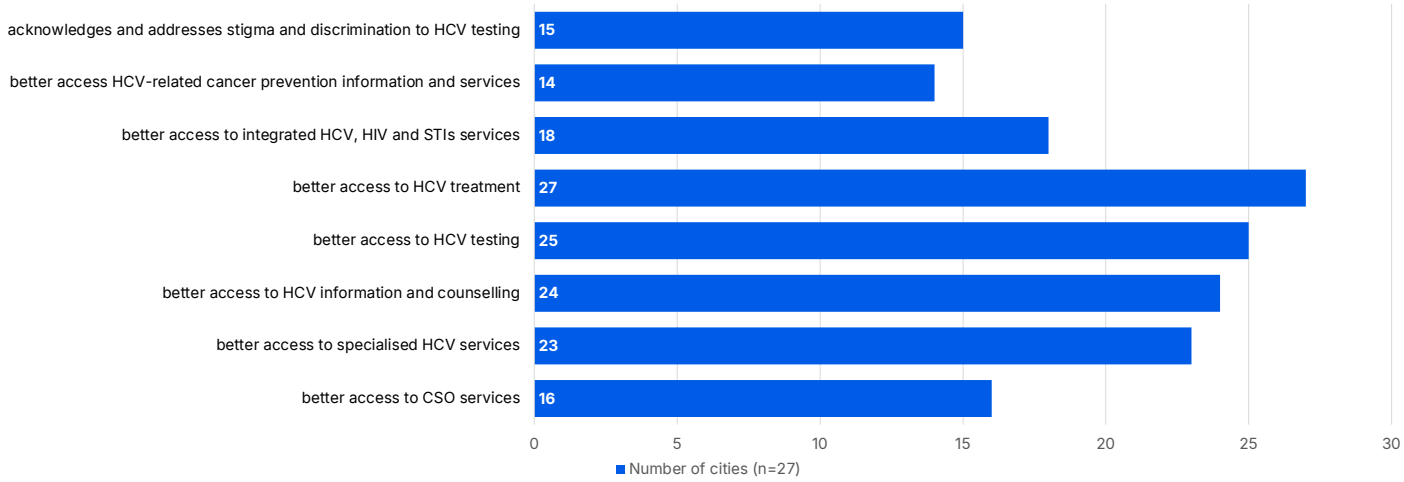


Figure 3. The guidelines' positive impacts on accessibility to testing and HCV treatment of people who inject drugs in your city (n=27). (Acronyms used in the figure: HCV: hepatitis C virus; HIV: human immunodeficiency virus; STIs: sexually transmitted infections; CSO: civil society organisation).

Three FPs – from Bratislava, Tallinn, and Tirana – believed that their guidelines had a negative impact, indicating that on account of the guidelines, HCV treatment cannot be conducted outside of specialised healthcare. One respondent, from Stockholm, evaluated that their recently launched Swedish guidelines had not yet yielded either a positive or negative impact.

Respondents could also comment on any missing issues of the existing guidelines (Box 1). Differences between the official documents and their implementation were pointed out, especially regarding the frequency of testing for opioid agonist/substitution treatment (OAT/OST), HCV treatment not being possible outside of specialised healthcare, or hepatologists still prescribing interferon. Moreover, groups - such as undocumented migrants - were referred as being left out.

Box 1

QUESTION: Is there any vital issue missing in those guidelines? Do you have other comments on the guidelines and their implementation?

FP from Tirana, Albania

"The guidelines were last adopted in 2017. Now we are in 2023 and a lot of things have changed, so the guidelines shall be revised. There shall be a stronger voice of people who use drugs to be better included".

FP from Antwerp, Belgium

"There is a difference between theory and practice - not all goals are reached"

FP from Balti, Moldova

"Not all protocol recommendations are practically implemented. For some recommendations, there is no mechanism of implementation. The most important level of protocol implementation are family doctors, who usually are not very friendly towards people who inject drugs, expressing a lot of stigma and discrimination and raising barriers for access".

FP from Bern, Switzerland

"People who use drugs are not aware of the existence of these guidelines".

FP from Bratislava, Slovakia

"The indicative limitations - where to get the treatment, also the rules of health insurance companies - they need to approve the treatment, so the doctor is not the one who is making decisions. The doctor can indicate the treatment but then the doctor needs to write an application for approval of the medication for the patient."

FP from Dublin, Ireland

"There are often discrepancies between guidelines and practice, for example the frequency of testing for those engaged in OST services - not as specified."

FP from Prague, Czechia

"It is terrible that there are still hepatologists prescribing interferon to people who use drugs."

FP from Copenhagen, Denmark

"There is no strategy for undocumented immigrants."

FP from Krakow, Poland

"Official statement of guidelines is that active substance using is exclusion from treatment, but our experience is that specialists are ignoring this statement."

FP from Podgorica, Montenegro

"The guidelines that do exist are vague and made more like an internal document. There are no procedures for testing and entry into treatment, but only the method of genotyping and adequate therapy for the genotyping is described. The new guidelines, which are not targeted, were written in collaboration with the infectious disease clinic, the public health institute and the NGO working with this community, so they are much more complex."

FP from Tallinn, Estonia

"HCV treatment is not possible outside the specialised healthcare system, HCV treatment is only prescribed by specialists (not even by a family doctor)."

Availability of, and access to, new drugs (direct acting antivirals, DAA's)

The new drugs for HCV treatment (direct acting antivirals, DAA's) were available in all cities. DAA's were accessible without restrictions in 25 cities (71.4%) and with restrictions in 10 cities (28.6%). A list of reported restrictions in each city is presented in Table 2.

City (country)	Restrictions related to state of liver fibrosis	Other restrictions
Balti (Moldova)	Accessible for F2, F3, F4	Accessible only for people on OAT; accessible only in specialised HCV settings.
Bratislava (Slovakia)	Accessible for F1, F2, F3, F4	Accessible only in specialised HCV settings; until 6/2023 one year of abstinence was required; now also people who use drugs have access to treatment.
Copenhagen (Denmark)	Accessible for F2, F3, F4	
Kyiv (Ukraine)	Accessible for F2, F3, F4	Accessible only in specialised HCV settings.

City (country)	Restrictions related to state of liver fibrosis	Other restrictions
Milan (Italy)		Accessible only in hospitals; accessible only in specialised HCV settings.
Podgorica (Montenegro)	Accessible for F1, F2, F3, F4	Accessible only for people who use drugs and stopped injecting drugs; accessible only for people who use drugs and enrolled on OAT; accessible only in healthcare settings.
Sofia (Bulgaria)		Need of health insurance.
Tirana (Albania)	Accessible only for F3 and F4 (cirrhosis)	Accessible only for people who are abstinent from drugs; accessible only in specialised HCV settings.
Vienna (Austria)		Health insurance covers the cost only if DAAs are prescribed by specialised centres; GPs and internal specialists are excluded.

Table 2. Reported restrictions in the use of DAA's for the treatment of hepatitis C (n=10).
(Acronyms used in the table: F: fibrosis stage according to METAVIR scoring system; OAT: opioid agonist treatment; HCV: hepatitis C virus; DAAs: direct acting antivirals; GPs: general practitioners.)

Where the guidelines allow the use of DAAs for people who inject drugs, they are made available for people who currently or ever injected drugs in 29/35 cities (82.9%); in 31/35 (88.6%) of cities it is applicable for people who formerly injected drugs but are no more injecting and are not on OAT; and in 32/35 cities (91.4%) it is applicable for people who are currently enrolled on OAT (Figure 4).

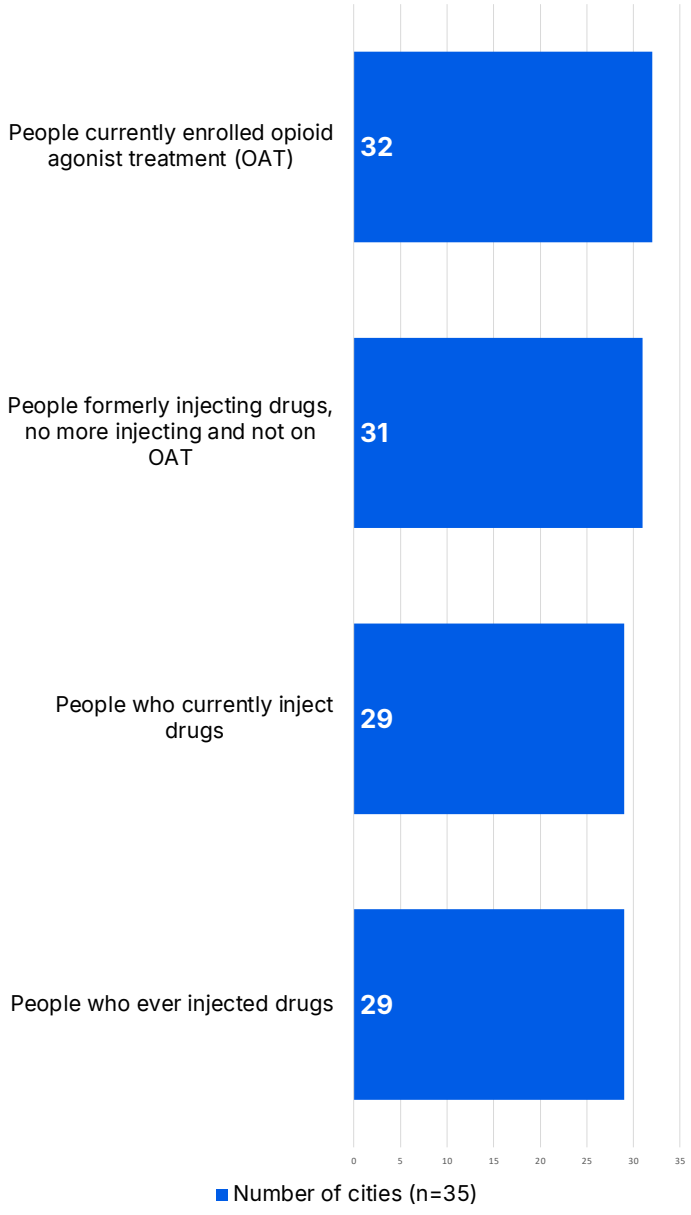


Figure 4. In case the guidelines allow the use of direct-acting antivirals (DAAs) for people who inject drugs, for whom are they applicable (n=35) (OAT: Opioid Agonist Treatment.)

Are DAAs used according to the official policy?

The great majority (33/35, 94.3%) of respondents reported that in their cities DAA's are used according to the official policy.
Similar to the response provided in 2022, the FP from Milan noted that "some doctors in practice discriminate against active drug users because they have doubts about their adherence to treatment and think they might get re-infected". The FP from London commented that, "There is no official policy on paper. Would probably not make a difference on-the-ground if there was a policy in this case, as treatment is widespread".

Stigma and discrimination towards people who use drugs

In 2023, an additional question was added to the survey asking if stigma and discrimination towards people who use drugs happens at different points of HCV care (testing and treatment) in the respondents' city. The respondents were not given any kind of definition of how stigma or discrimination is defined or should be assessed.

Stigma and discrimination are most commonly reported in prison settings and at general practitioners (GPs) (20/35 each, respectively; 57.1%), and are also common at gastroenterology clinics (18/35, 51.4%), at infectious disease clinics (15/35, 42.9%), and at drug treatment clinics (11/35, 31.4%) (Table 2). Stigma and discrimination are least common in harm reduction services (3/35, 8.6%). Focal points from 6/35 cities (17.1%) (Helsinki, Krakow, Ljubljana, Luxembourg, Paris and Rome) answered that there is no stigma or discrimination in any of these points of care. The FP from Malta did not know if stigma or discrimination happens in any of the locations for HCV care. The FP from Podgorica did not know if there was any stigma and discrimination but commented that, "All the research done in the past years which refer to the stigma and discrimination of people who use drugs or are on some kind of OAT, shows that the highest degree of stigma and discrimination is within the health system of Montenegro".

As shown in Table 3, cities where stigma and discrimination were reported from most or even all care points included Amsterdam, Athens, Thessaloniki, Budapest, Balti, Glasgow, various cities in Iceland (including Reykjavik), Kyiv, Sofia, and Vienna.

On the other hand, it is not always an either-or situation, as the FP from Berlin comments, "In all sites there can be stigma. But for every site, there are institutions or persons where there is no stigma."

City	Gastro-enterology Clinics	Infectious Disease Clinics	Drug Treatment Clinics	Harm Reduction Services or Community Centres	General Practitioners	Pharmacies	Prisons
Amsterdam		●	●	●	●	●	●
Antwerp							●
Athens/Thessaloniki	●	●			●	●	●
Balti	●	●	●		●	●	●
Barcelona	●	●			●	●	
Berlin	●				●	●	
Bern							●
Bielefeld							●
Bratislava	●	●					
Budapest	●	●	●		●	●	●
Copenhagen	●	●	●		●	●	●
Dublin	●	●	●		●	●	●
Glasgow	●	●	●	●	●	●	●
Helsinki							
Iceland	●				●		●
Krakow							
Kyiv	●	●	●		●	●	●
Ljubljana							
London							
Luxembourg							
Malta	Don't know	Don't know	Don't know	Don't know	Don't know	Don't know	Don't know
Milan	●	●			●	●	●
Newport					●		
Nicosia	●				●	●	
Paris							
Podgorica	Don't know	Don't know	Don't know	Don't know	Don't know	Don't know	Don't know
Porto			●		●	●	●
Prague	●	●			●	●	●
Roma							
Sofia	●	●	●		●	●	●
Stockholm					●		●
Tallinn							●
Tirana	●						
Vienna	●	●	●	●	●	●	●
Warsaw	●	●	●		●	●	●
n	18	15	11	3	20	16	20

Table 3. Does stigma and discrimination towards people who use drugs happen at the following points of HCV care (testing and treatment) in your city? Please select all that apply **(n=35)**.

The FP from London did not choose one of the treatment place options but commented on the topic as follows: "*Stigma still exists against people who use drugs in all settings. Thankfully, in the HCV context, so much of the face-to-face interaction with people being tested and treated today is by peers with similar lived experiences, meaning that the spaces where stigmatising treatment towards people who use drugs could occur are quite limited. Testing is conducted by peers; in some areas, Fibroscans are also done by peers; peers bring electronic tablets to people and video call nurses with them where they are; and then those same peers come to deliver prescriptions on outreach to people who need them – it is a very thorough system. The widespread prevalence of peer workers not only serves as a protective factor against discrimination towards people who use drugs but helps to battle stigma more broadly in the sector through the platforming of lived and living experience as a valid form of expertise*". (FP from London)

The questionnaire for the last two observational years also contained a question asking if stigma and discrimination towards people who use drugs at the point of care is being monitored and addressed in the respondent's city (Figure 5). Only in 8/35 cities (22.9%) was stigma and discrimination reported as being monitored, whereas in 24/35 cities (68.6%) it was not.

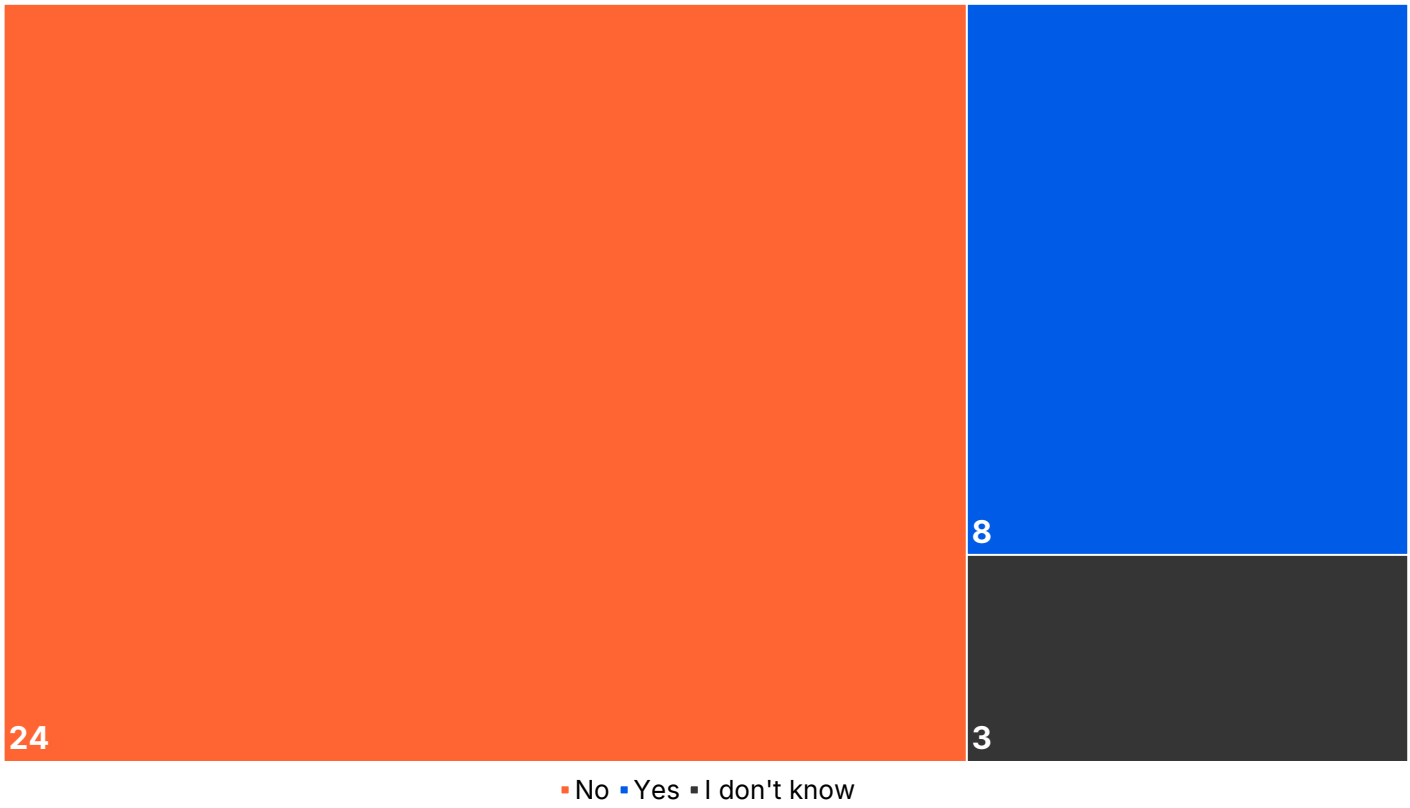


Figure 5. Is stigma and discrimination at point of care towards people who inject drugs being monitored and addressed in your city? **(n=35)**

Who is paying for HCV treatment?

HCV treatment with DAAs was reported to be reimbursed by health insurance or by the public health service in almost all included countries. Only in Albania and Montenegro were DAA's not reimbursed. In 2023, 19/35 (54.3%) of FPs reported that treatment with the new drugs is reimbursed with no limitations, whereas 14/35 (40%) of FPs reported that there are limitations.

The FPs were also asked if treatment with DDAs is reimbursed for people who inject drugs without insurance. Altogether, 25/35 (71.4%) of FPs reported that treatment is also reimbursed without insurance in their country; in 16/35 (45.7%) it is without limitations and in 9/35 (25.7%) it is with some limitations (Figure 6). For example, for undocumented immigrants who inject drugs, DAAs are not reimbursed. In Albania, Austria, Estonia, Germany, Greece, Hungary, Iceland, Montenegro, Poland, and Switzerland treatment with DDAs is not reimbursed for people who inject drugs without insurance.

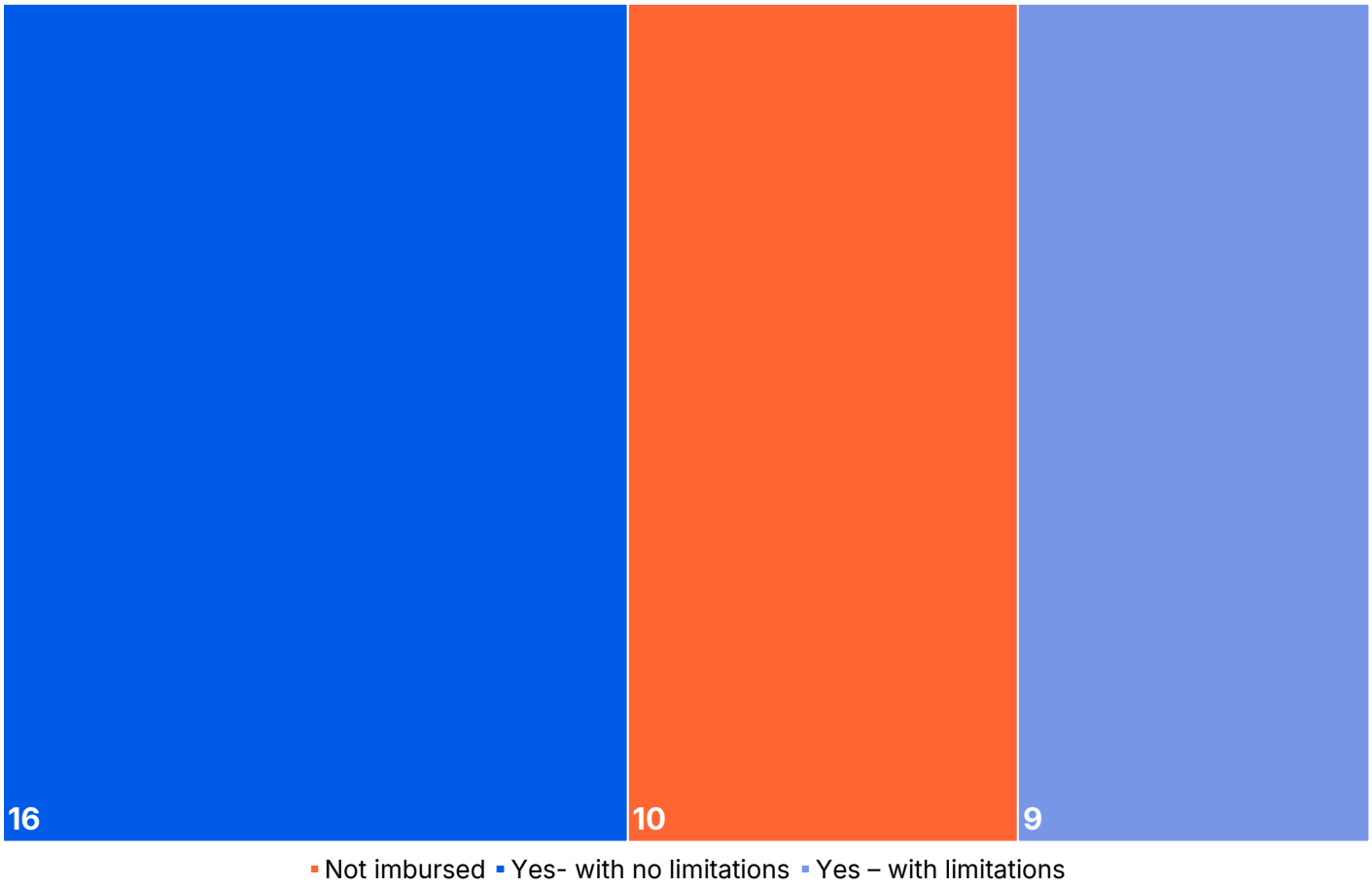


Figure 6. Is treatment with the new drugs for hepatitis C (DAAs) reimbursed for people who inject drugs without insurance? **(n=35)**.

As can be seen from the quotations below, in case limitations in the reimbursement of DAAs were reported, these were most often linked to people not having official documents, registration numbers (often the case for undocumented migrants), social security or medical insurance.

Box 2

Reported limitations for using DAAs

FP from Vienna

"Health insurance covers the cost only if DAAs are prescribed by specialised centres. GPs and internal specialists are excluded for that."

FP from Antwerp

"Only if you have social security or another legal statutory [document]. People without papers can have an exemption in emergent medical care. If not, sometimes we can work with samples (limited)."

FP from Sofia

"Only people who have IDs and health insurance are able to receive treatment."

FP from Nicosia

"For undocumented immigrants only, there has to be an exemption by the Minister of Health in order to receive treatment free of charge."

FP from Prague

"Reinfections are reimbursed only if it's a different genotype of HCV than the one already cured."

FP from Copenhagen

"Undocumented migrants are not reimbursed."

FP from Tallinn

"Treatment is available only for people with medical insurance."

FP from Berlin

"Only via individual health insurance, not via medical aid by public health agencies. Very limited possibility to get reimbursement by the "clearing office" for people without health insurance."

FP from Athens and Thessaloniki

"Access to DAA's is open and free of charge if you have a social security record number. For many migrants and refugees, this is not the case and also for some other foreigners."

FP from Malta

"A number of patients who show less enthusiasm and persistence to engage with specialised treatment services often complain that they were left without treatment if they miss appointments at the hospital. While specialists have started attending the only prison in Malta to facilitate engaging individuals suffering from chronic HCV, they have shown resistance to attend the only facility in Malta where methadone is prescribed and dispensed in the community. This is known to be the main source of referral to hospital of patients infected with HCV."

Changes in the continuum-of-care

In 2023, for the second time, the FPs were queried about the availability of free testing in their respective countries. Free testing is accessible in all countries of the FPs responding to the survey: it is generally available in 22/35 cities (62.9%), and only at specific testing points in 13/35 cities (37.1%). These specific testing locations include harm reduction services or family doctors (e.g. Balti, Moldova); OAT centres; consumption rooms; street outreach; GPs (Bielefeld, Germany); harm reduction services; drug treatment; most hospitals but not all (Milan, Italy); a single drop-in centre (Sofia, Bulgaria); healthcare settings by medical staff (Tallinn, Estonia); a few harm reduction outreach services (Budapest, Hungary); consultation and diagnostic points; mobile harm reduction units (Warsaw, Poland); sporadically at drug dependence centres; occasionally at rehabilitation centres or prisons (Bratislava, Slovakia); and exclusively within specific projects (Bern, Switzerland).

In the majority of cities (25/35, 71.4%), a prescription for testing is not needed. In 7/35 cities (20%), such a prescription is required "sometimes"; these cities include Balti, Bielefeld, Krakow, Paris, Porto Rome, and Vienna. A prescription for testing is always necessary only in Iceland and Podgorica (Montenegro) (Figure 7).

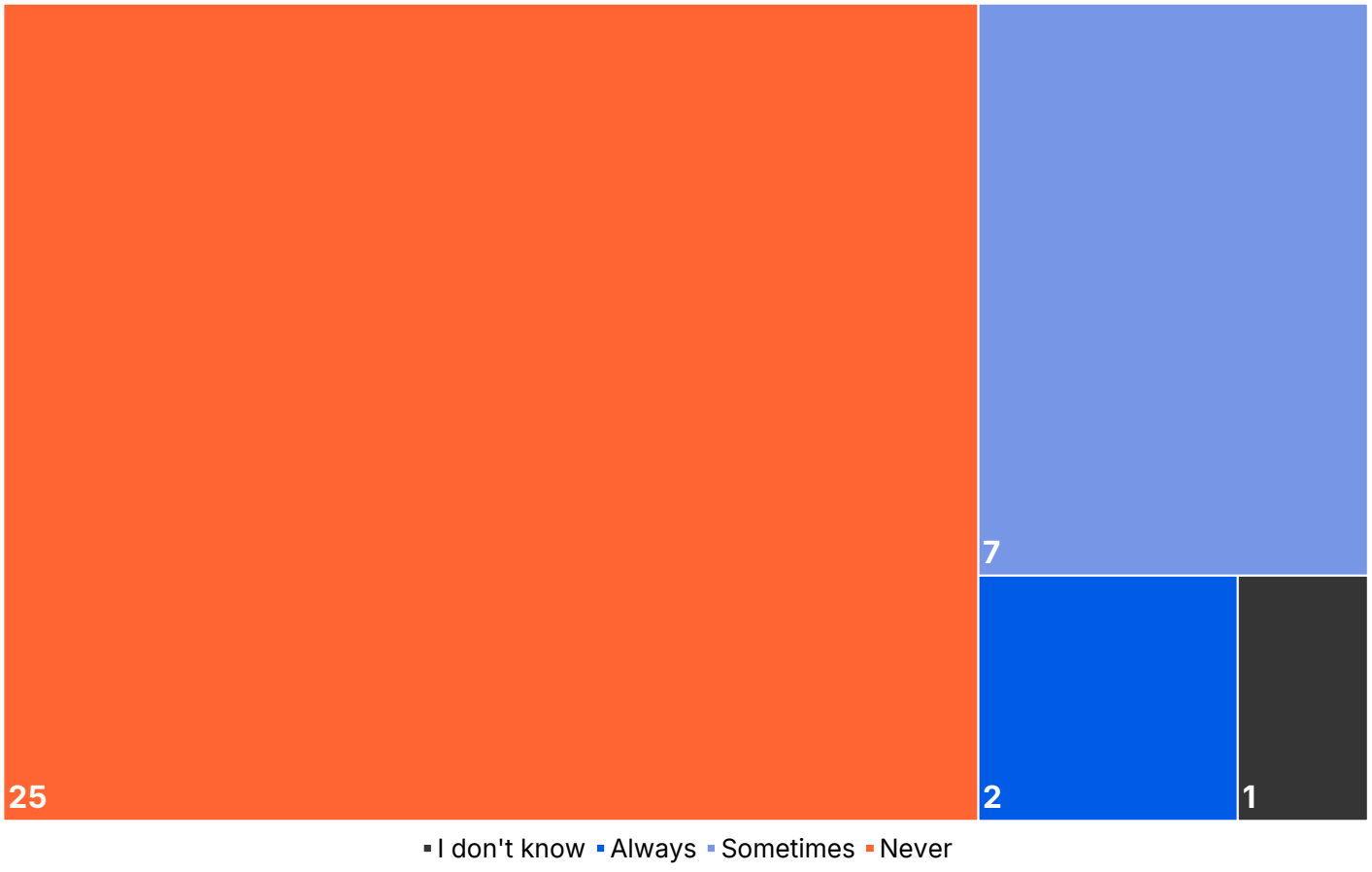


Figure 7. Does HCV testing for people who inject drugs require a prescription? **(n=35)**.

As in the previous year, confirmatory HCV testing performed at various settings was reported from a similar number of cities; in 16/35 cities (45.7%) confirmatory testing can also be conducted in harm reduction services (Figure 8).

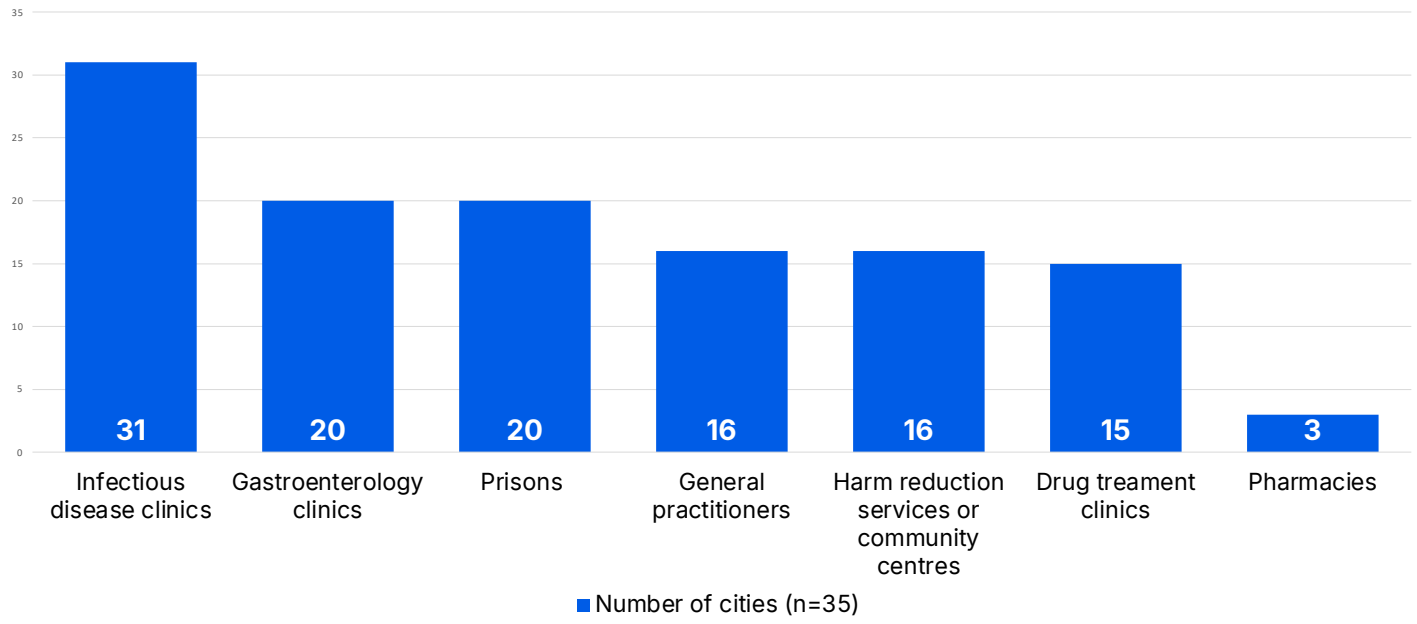


Figure 8. Where can people who inject drugs perform a confirmatory blood test for HCV RNA? **(n=35)**

"We can offer on-site quantitative HCV PCR testing using the GeneXpert® machine. The users of the consumption room know 'us'. We have the great advantage that we have an established practice that does dependence medicine and the 'drug help centre' with a low-threshold consumption room on one site, so quasi "under one roof", and the distances are therefore short, and we have social workers, medical staff and doctors on site. Through a project application, we can finance this testing procedure and thus identify the people who have an HCV infection requiring treatment within just one hour." (FP from Bielefeld)

Non-invasive diagnostics

In 2023, a non-invasive diagnostic procedure (i.e. Fibroscan®) for HCV-infected people who inject drugs to evaluate the stage of liver disease was most commonly available at gastroenterology clinics in 24/35 cities (68.6%) and at infectious disease clinics in 23/35 cities (65.7%). In prisons, it can be performed in 9/35 cities (25.7%), at drug treatment centres in 8/35 cities (22.7%), and at GPs only in 2/35 cities (5.7%) (Figure 10). At harm reduction services, Fibroscan® can be used in 8/35 cities (22.9%): London, Helsinki, Paris, Dublin, Luxembourg, Barcelona and Newport.

"Fibroscan increasingly used across all areas and access is improving but can still be improved. While liver staging before treatment is considered best practice, it can be done after – it is better that it doesn't get in the way of treatment at the end of the day. There are 18 vans around England which contain Fibroscan machines. These vans go anywhere and often park outside homeless centres and hostels but also outside of common public places like supermarkets. In some areas, peers have been trained to conduct the Fibroscans as well. Even without the Fibroscan, you can diagnose liver stage using bloods and this is also still done in some contexts." (FP from London)

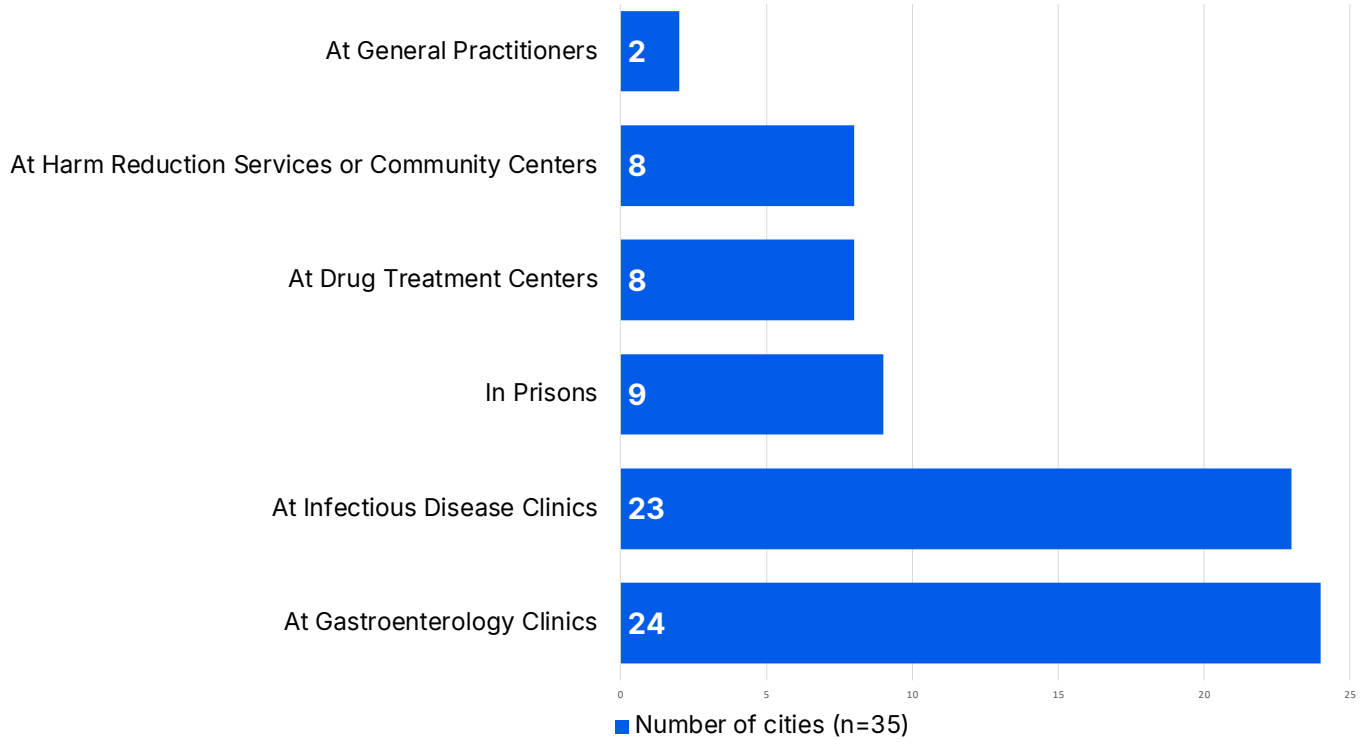


Figure 9. Where can HCV-infected people who inject drugs perform a non-invasive diagnostic procedure for the evaluation of the stage of liver disease (i.e. Fibroscan®)? **(n=35)**

Where can people who inject drugs be treated for hepatitis C

People who use drugs can have DAA treatment at infectious disease clinics (29/35 cities, 82.9%)) and gastroenterology clinics (25/35 cities, 71.4%). DAA treatment is available in drug treatment in 18/35 cities (51.4%), in prisons in 19/35 cities (54.2%), at harm reduction services or community centres in 12/35 cities (34.3%), and at GPs in 12/35 cities (34.3%) (Table 4).

City	Gastro-enterology Clinics	Infectious Disease Clinics	Drug Treatment Clinics	Harm Reduction Services or Community Centres	General Practitioners	Pharmacists	Prisons
Amsterdam	●						
Antwerp	●						
Athens/Thessaloniki	●	●					●
Balti		●					
Barcelona	●		●	●			●
Berlin	●	●	●		●		●
Bern	●	●	●		●		●
Bielefeld	●	●	●		●		
Bratislava	●	●					
Budapest		●					
Copenhagen	●	●	●	●			
Dublin	●	●	●		●		●
Glasgow	●	●	●	●	●	●	●
Helsinki	●	●		●	●		●
Iceland	●	●	●	●			●
Krakow	●	●					●
Kyiv		●					
Ljubljana	●	●					
London	●		●	●	●	●	●
Luxembourg		●	●	●			●
Malta		●			●		
Milan		●					●
Newport	●		●	●			●
Nicosia		●					
Paris	●	●	●	●	●		●
Podgorica		●					
Porto		●	●	●		●	●
Prague	●	●	●	●	●		●
Roma	●	●					
Sofia	●	●	●	●	●		●
Stockholm	●	●	●				●
Tallinn	●	●	●		●		●
Tirana	●						
Vienna	●	●	●				●
Warsaw		●					X
n	25	29	18	12	12	3	21

Table 4. In case the direct acting antivirals (DAAs) are accessible for people who inject drugs, where can they be treated for hepatitis C? **(n=35)**

Who can prescribe DAAs

The data indicates the varying prescription rights for DAAs among different medical professionals across the surveyed European cities. In 2023, infectious diseases specialists and gastroenterologists/hepatologists were the groups most commonly reported to have prescription rights, in 30 cities (85.7%) and in 29 cities (82.9%) respectively (Figure 10).

"GPs could technically prescribe but in practice it is all within gastroenterology specialist care - all decisions made in a multi-disciplinary team (MDT), after which a nurse can do the prescribing so long as it is to be monitored in a MDT going forward. The pay mechanism is the issue which prevents GP prescribing. GPs can't prescribe the DAAs at the reduced price that NHS-E has secured in the elimination plan. If a GP prescribed DAAs, then the dispensing chemist has to buy the DAAs at standard cost and get reimbursed, which would be prohibitive. Mobile outreach clinics are increasingly the norm for prescribing. Pharmacists in some areas are also directly prescribing now." (FP from London)

"A GP must undergo an additional training module in order to prescribe." (FP from Dublin)

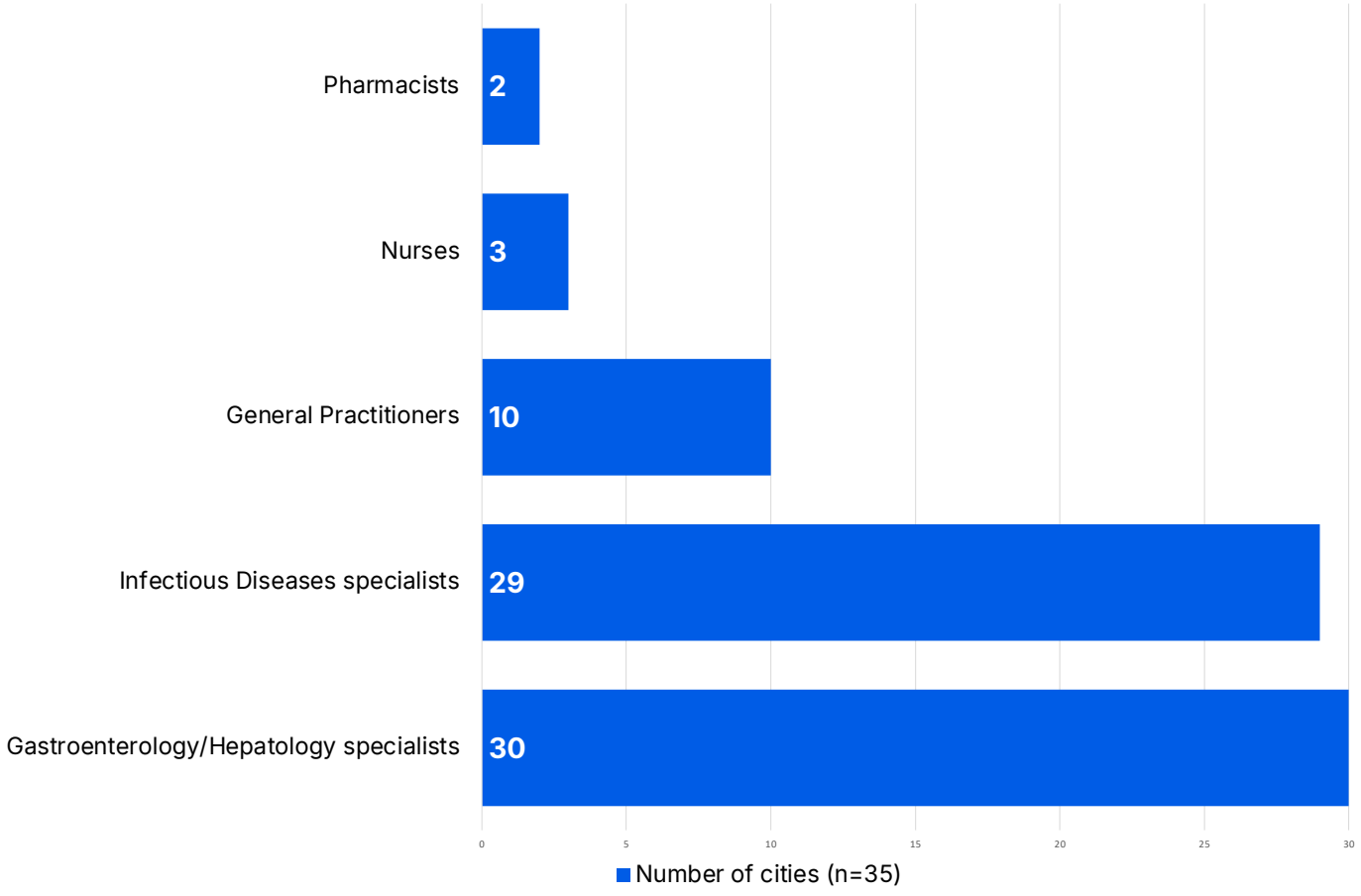


Figure 10. Who can legally prescribe direct acting antivirals (DAAs)? **(n=35)**

Are there written guidelines for the linkage-to-care?

Respondents were asked if the linkage-to-care for people who inject drugs is achieved by a written protocol or guideline (Figure 12). More concretely, they were asked to assess if there is, for instance, an agreed protocol to refer clients from harm reduction services to other treatment and care systems. In 2023, there were 17/35 (48.6%) cities where linkage-to-care is achieved by written guidelines and another 15/35 (42.9%) cities where it is not (Table 5).

In 2023, the only 'I don't know' answer came from Malta: "*Government runs services. No NGO provides harm reduction services; however, there is dialogue between treatment services and national health services.*" (FP from Malta)

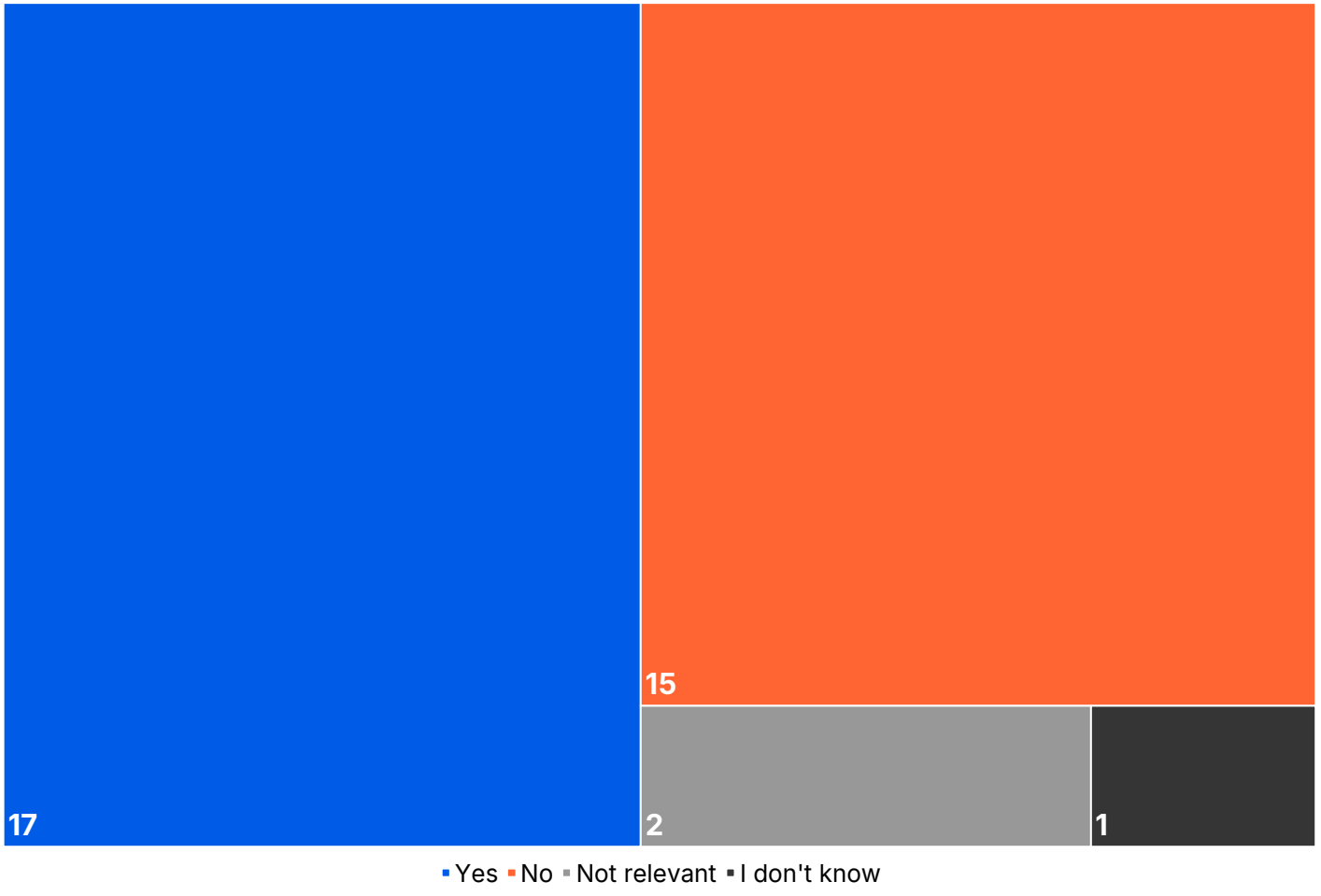


Figure 11. Is linkage-to-care for people who inject drugs achieved by a written protocol/guidelines? Think of an agreed protocol to refer clients, e.g. from a harm reduction service to other treatment and care **(n=35)**

No (n=15)	Yes (n=17)	Not relevant (n=2)	I don't know (n=1)
Athens & Thessaloniki Berlin Bratislava Budapest Copenhagen Dublin London Nicosia Podgorica Rome Sofia Stockholm Tirana Warsaw Vienna	Amsterdam Balti Barcelona Bern Glasgow Milan Newport Krakow Kyiv Ljubljana Luxembourg Porto Prague Tallinn Helsinki Iceland Paris	Antwerp Bielefeld	Malta

Table 5. Is linkage-to-care for people who inject drugs achieved by a written protocol/guidelines? Think of an agreed protocol to refer clients, e.g., from a harm reduction service to other treatment and care. **(n=35)**

Monitoring schemes

For the second consecutive year, an additional question was posed regarding the presence of monitoring schemes for post-diagnosis/post-treatment follow-up of individuals who use drugs with HCV, aimed at averting liver damage and preventing liver cancer. In 22/35 of cities (62.9%), such schemes were in place, while in 8/35 of cities (22.9%) they were unavailable. This is the case in Amsterdam. Bratislava, Kyiv, Milan, Podgorica, Sofia, Tirana and Warsaw (Figure 12).

Four out of 35 cities (11.4%) reported monitoring schemes with restrictions. In Vienna, monitoring is not systematic and occurs exclusively within specific projects. In Dublin, monitoring is described as sporadic and reliant on individual practitioners involved. In Malta, only individuals entering drug rehabilitation treatment undergo follow-up. The Focal Point from London provides a more detailed account of the current situation:

> ***"Monitoring is an issue currently. The Hepatitis C Trust's role is if someone is cirrhotic or fibrotic, then they will follow up annually. Otherwise, post-diagnosis follow-up is generally not great. More needs to be done, but if people are in drug treatment, then the drug treatment services should pick this up, ideally – unfortunately, in practice, this does not happen."***

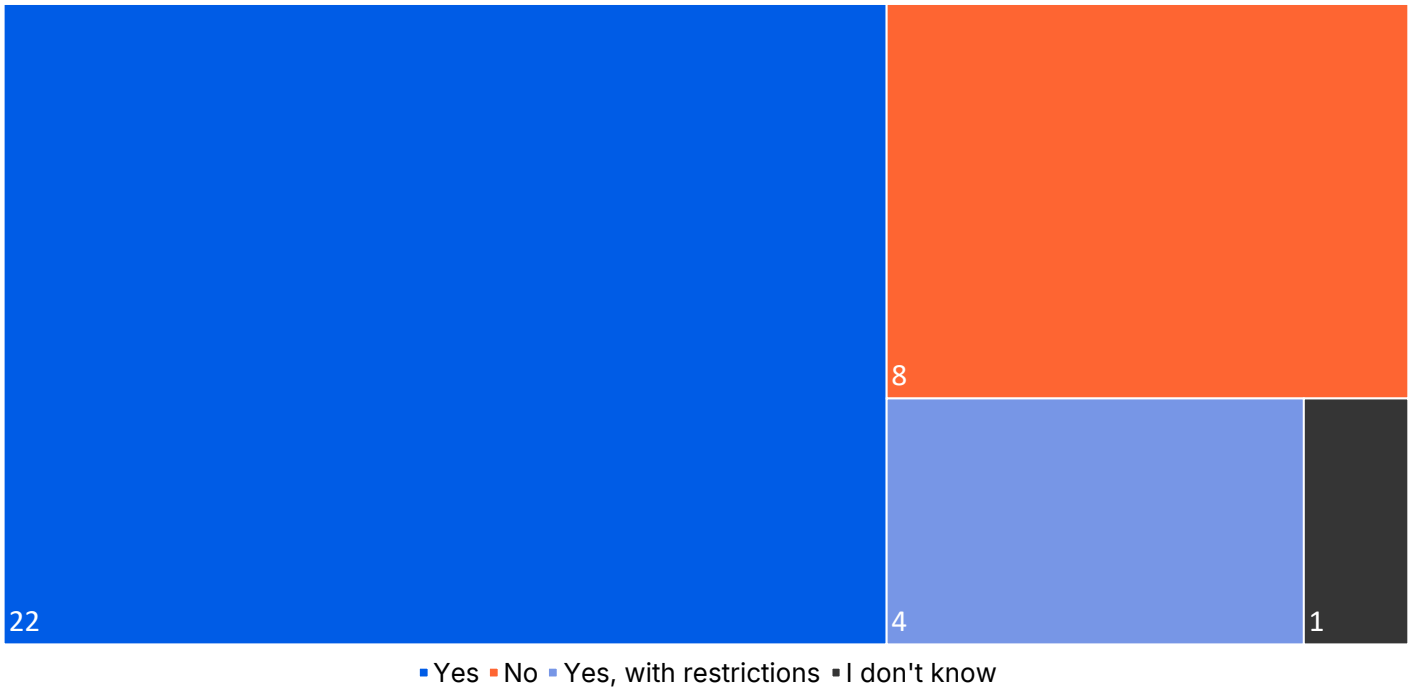


Figure 12. Are monitoring schemes in place for the post-diagnosis follow up and monitoring of people who inject drugs with HCV to avoid liver damage and prevent liver cancer? **(n=35)**

Perception of more or less action and coordination on HCV?

Focal Points were also asked to compare changes perceived by them in HCV activities between 2023 and the preceding year. They were queried about whether service providers in their cities had increased or decreased their focus on HCV awareness campaigns, testing at local sites, and treatment at local facilities. Compared to 2022, improvement was observed in 2023 across several dimensions in numerous cities (Figure 13).

In none of the cities has the investments in HCV awareness campaigns worsened. Positive changes were noted in 10/35 cities (28.6%), and the situation remained consistent in 18/35 cities (51.4%). In Malta, the respondent was unsure about changes in this area. Cities, where no attention was paid to HCV awareness campaigns, included Balti, Dublin, Iceland, Sofia, Stockholm and Warsaw.

HCV testing services seemed to have improved in many cities, rebounding after the years of the COVID-19 pandemic. In 2023, 17/35 respondents (48.6%) reported testing improvements, while 15/35

cities (42.9%) maintained the same standards as previously. Importantly, none of the respondents observed negative trends in testing over past year. Cities where no attention was paid to HCV testing included Sofia, Stockholm and Warsaw.

Regarding non-invasive diagnostic procedures like Fibroscan®, 8/35 cities noted improvement, while in the majority (20/35, 57.1%), those services remained unchanged. Encouragingly, no city reported worsening in non-invasive diagnostic procedures. Cities, where no attention was paid to non-invasive diagnostic procedures included Sofia and Warsaw.

Compared to the previous year, in 2023 HCV treatment services improved in 14/35 cities (40.0%) and remained stable in 17/35 cities (48.6%). In Kyiv, in the middle of the war of Russian aggression, HCV treatment experienced a decline. Cities where no attention was paid to HCV treatment included Sofia and Warsaw.

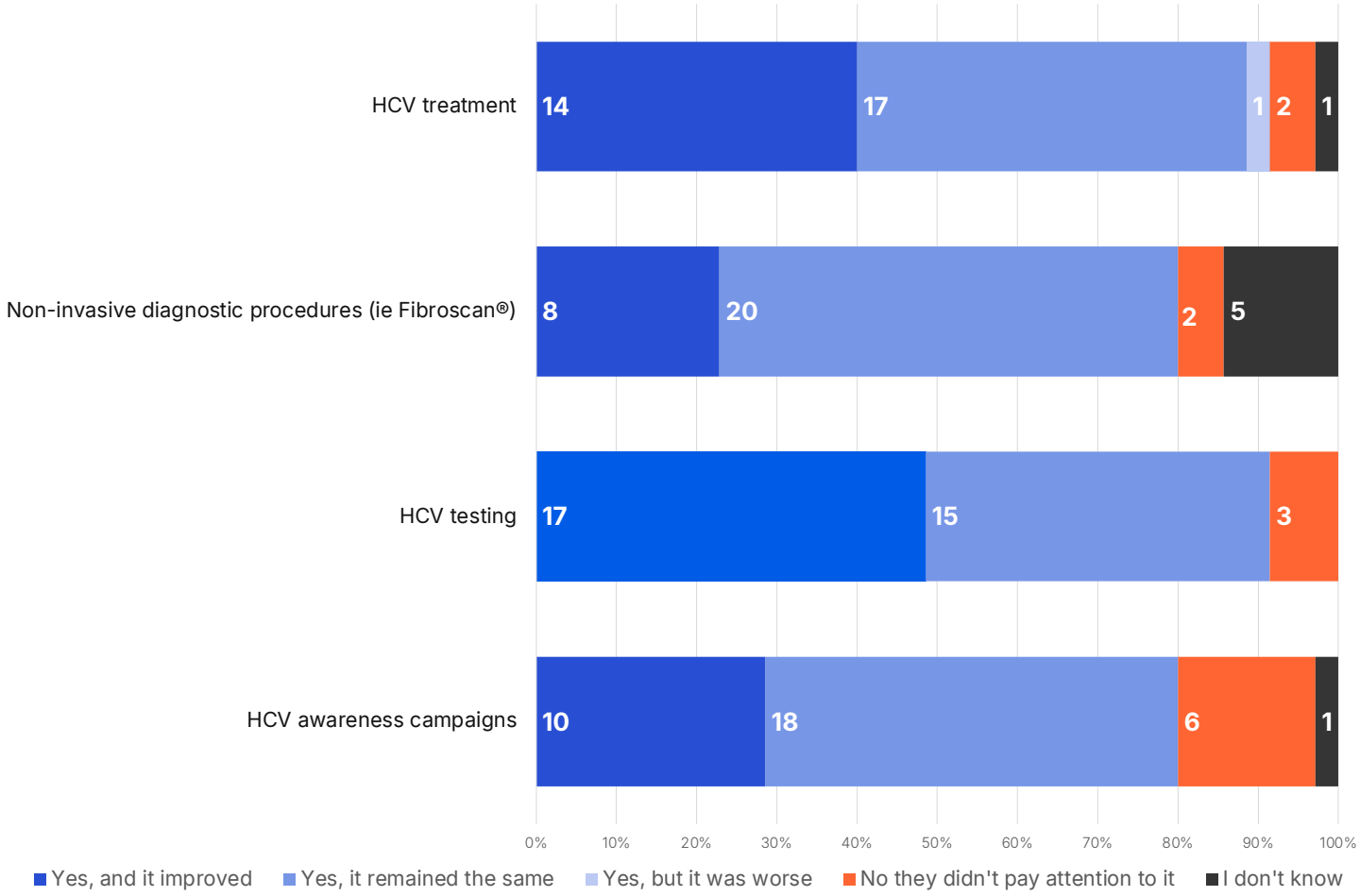


Figure 13. Have services assisting people who inject drugs in your city implemented activities in the following topics in 2022 compared to 2021? **(n=35)**

Compared to the previous year, coordination of information and data sharing, communication and service provision between health care providers (GPs, clinics) and social service providers (like NGOs, harm reduction services), remained the same or improved in most cities (Figure 14). Only in one city, Dublin, all three dimensions were assessed to have gotten worse. Communication was also reported to have gotten worse in Stockholm.

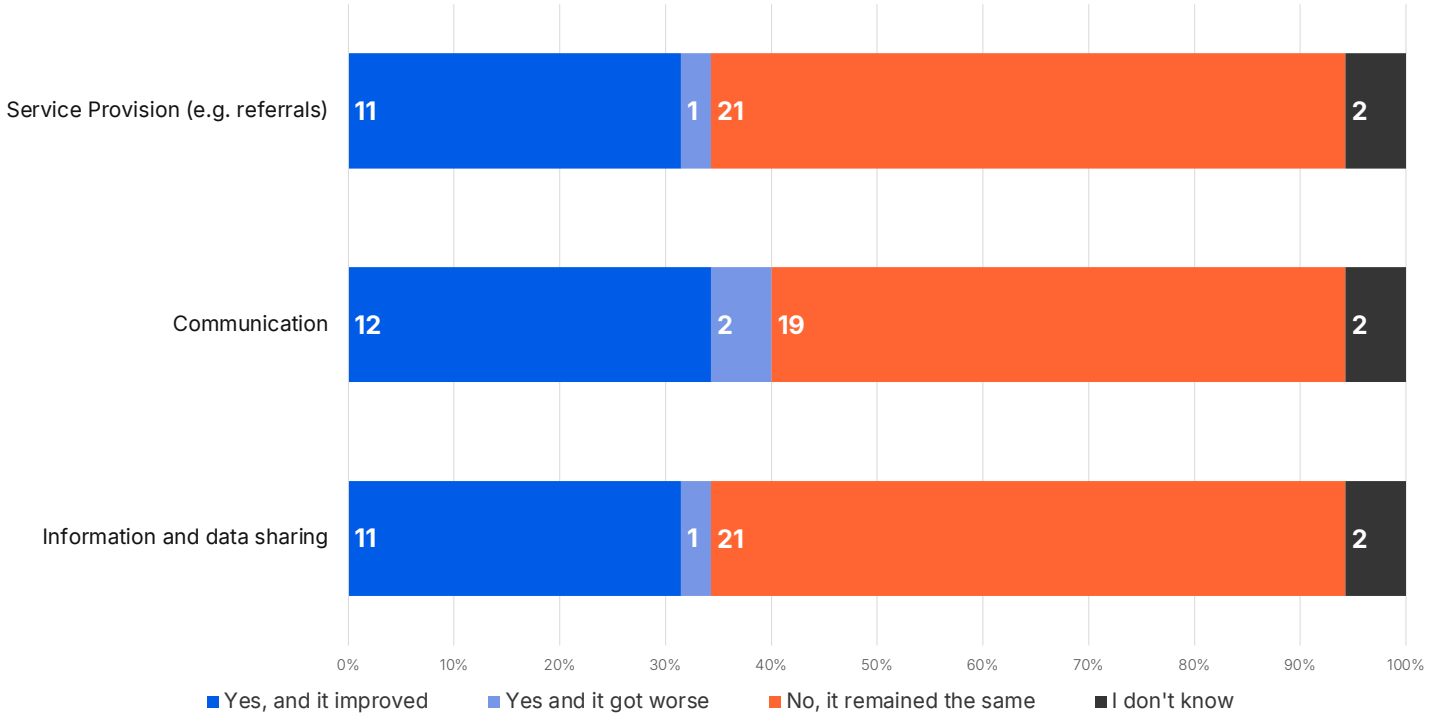


Figure 14. Compared to last year (2022), did the coordination change this year (2023) between health care providers (GPs, clinics) and social service providers (like NGOs, harm reduction services) regarding HCV? **(n=35)**

The role of harm reduction organisations

The Focal Points were asked if there are limitations for harm reduction organizations in addressing HCV in their cities. In 2023, altogether 17/35 cities (48.6%) reported limitations (Figure 15). The most frequently mentioned limitations included the lack of funding (13/35, 37.1%); lack of integration with the healthcare system (13/35, 37.1%); lack of staff (10/35, 28.6%); and lack of recognition and political support (8/35 each, respectively; 22.9%).

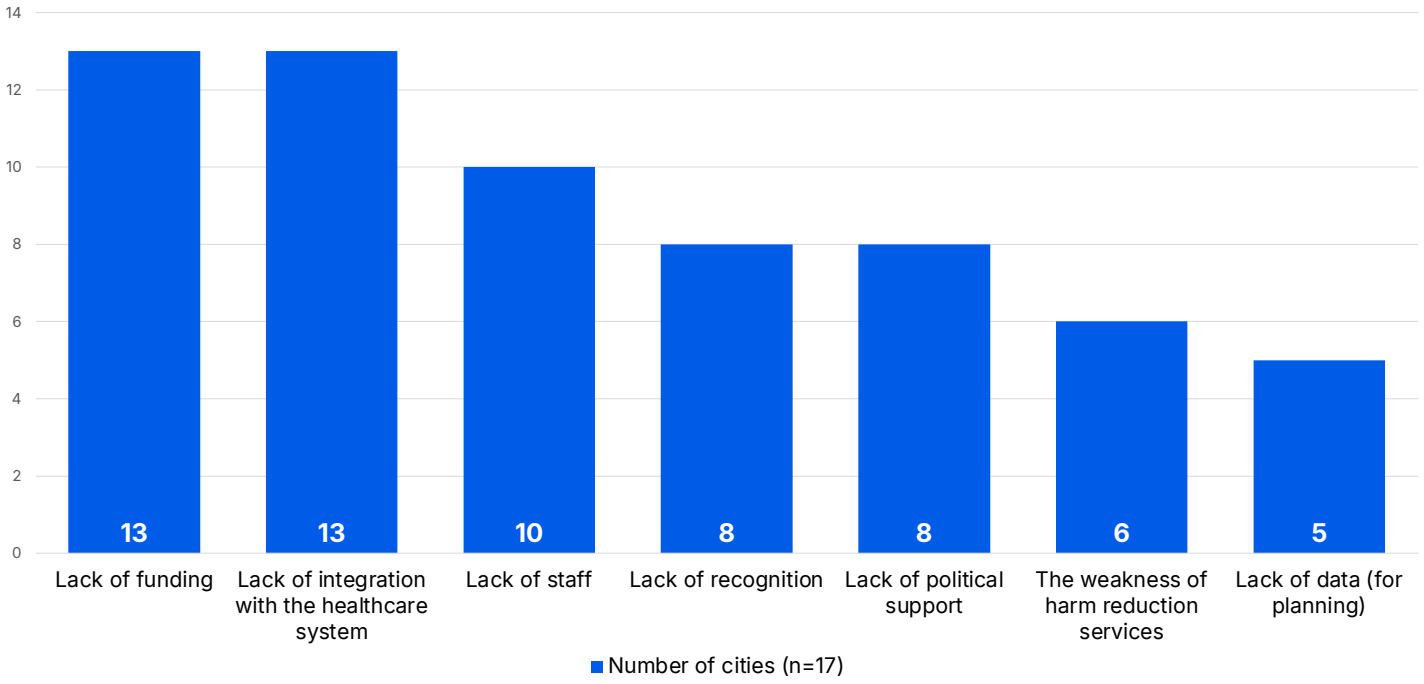


Figure 15. Limitations for harm reduction organisations in addressing HCV **(n=17)**

Development of interventions for HCV management for people who inject drugs over the period 2020-2023

Respondents from 25 cities[8] (Map 1, Page 10) were permanently included in the study over the period 2020-2023. For some of the questions that have not been changed over this period and have been answered each year by the same respondents, a comparison of responses has been made over the study period 2020-2023 to observe the possible development of achievements. The composition of this group of 25 cities is somewhat skewed towards Western and Northern Europe.

8. These 25 FPs include: Amsterdam (Netherlands); Antwerp (Belgium); Athens-Thessaloniki (Greece); Barcelona (Spain); Berlin (Germany); Bern (Switzerland); Bratislava (Slovakia); Budapest (Hungary); Copenhagen (Denmark); Cracow (Poland); Dublin (Ireland); Glasgow (Scotland); Helsinki (Finland); Ljubljana (Slovenia); London (England, UK); Luxembourg (Luxembourg); Milan (Italy); Nicosia (Cyprus); Paris (France); Porto (Portugal); Prague (Czechia); Stockholm (Sweden); Tallinn (Estonia); Tirana (Albania); and Vienna (Austria).

Comparison of development in 25 cities in period 2020-2023: testing for active HCV infection

When comparing the four years in 25 cities that have responded to the question every year on the settings for confirmatory testing for active HCV infection, the general picture is that, with the exception of prisons and pharmacies, there has been a decline in the proportion of cities testing from 2020 to 2023 in every other setting (Figure 16).

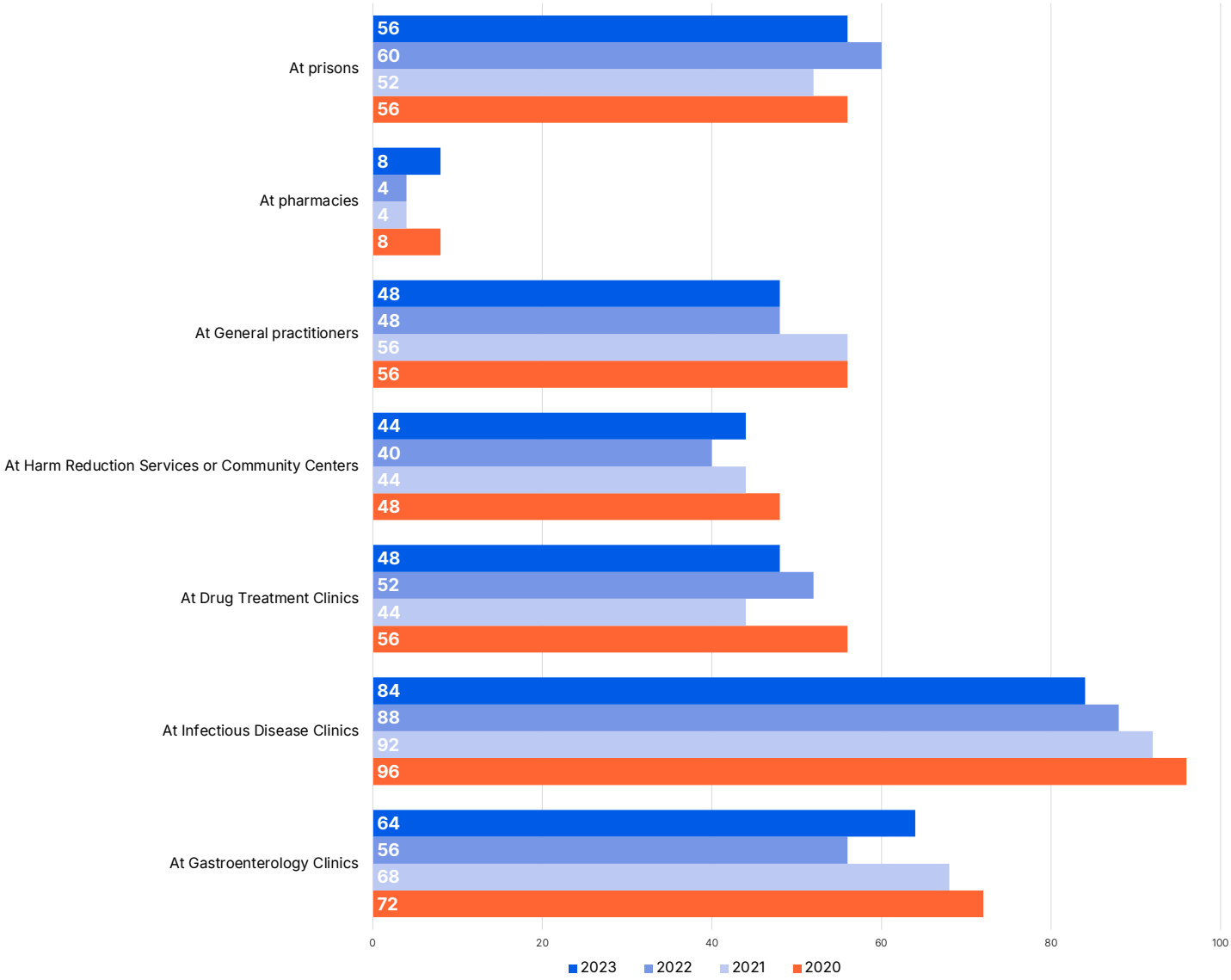


Figure 16. Proportion of European cities performing confirmatory blood testing for HCV RNA of people who inject drugs at various settings in four consecutive years, period 2020-2023 **(%, n=25)**

Comparison of development in 25 cities during the period 2020-2023: treatment settings

Over the period from 2020 to 2023, the distribution of treatment locations providing access to DAAs for people who inject drugs have remained largely similar. Infectious disease clinics consistently have been most common places for treatment, followed by gastroenterology clinics. For treatment within prisons, there is a notable increase from 2020 to 2023. There is also a slight increase for treatment in pharmacies and general practitioners.

The increase from 2022 to 2023 in treatment offered at harm reduction services and drug treatment centres might be explained by restrictions during the pandemic in other treatment facilities. The general picture, however, is that the settings for hepatitis C treatment have remained mostly the same in the majority of cities (Figure 17).

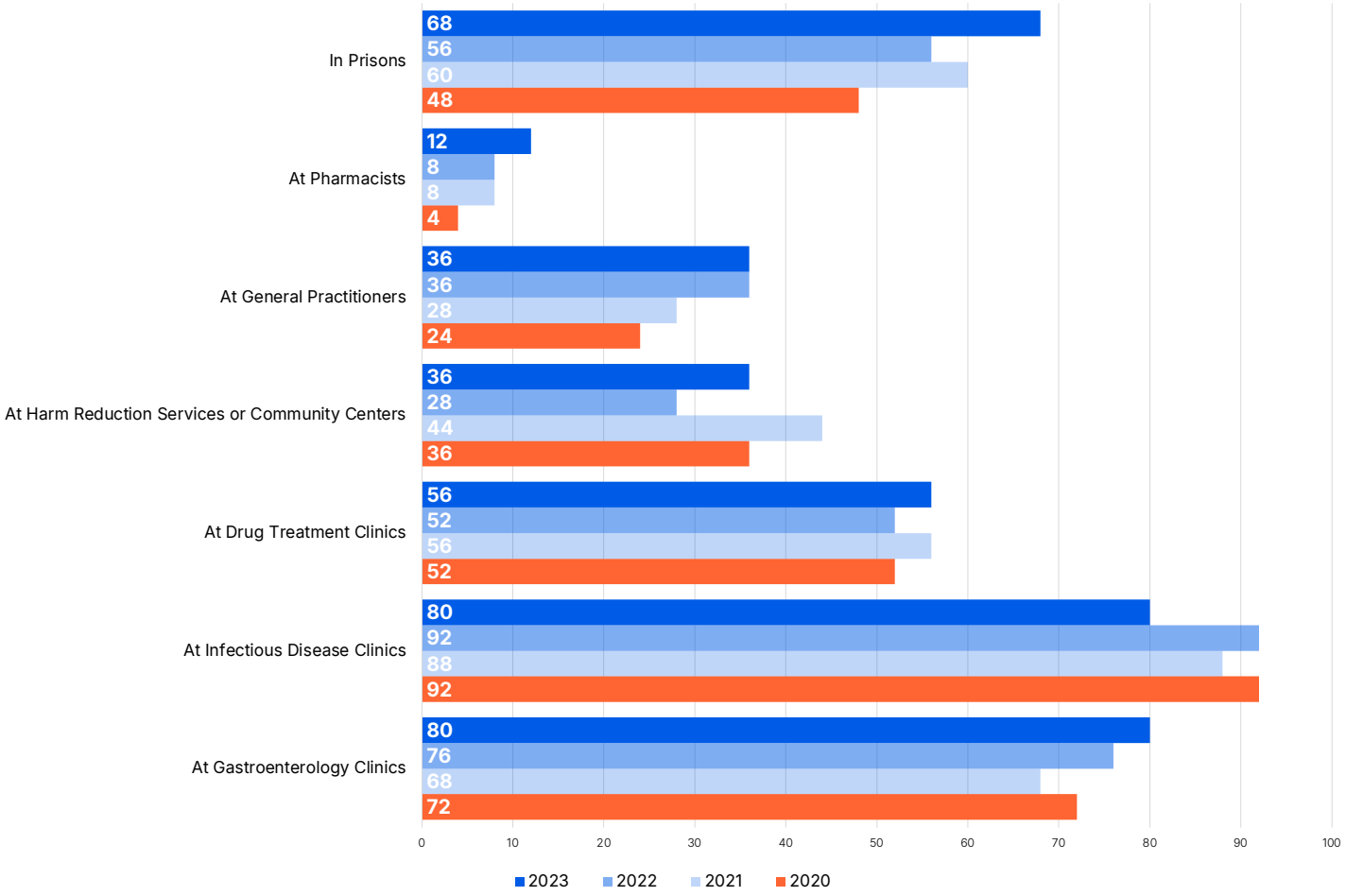


Figure 17. Proportion of European cities providing hepatitis C treatment for people who inject drugs at various settings during 2020-2023 **(%, n=25)**

Comparison of development in 25 cities during 2020-2023: written guidelines on linkage-to-care

Every year from 2020 to 2023, the respondents from 25 cities have reported if the linkage-to-care for people who inject drugs is achieved by a written protocol or guideline. This can take place, for instance, in the form of an agreed protocol to refer clients from harm reduction services to other treatment and care systems. In 2023, in exactly as many cities (both 48%), the linkage-to-care is and is not guided by such a protocol. The share of cities where the existence of a protocol uncertain, or is not regarded relevant, has clearly decreased (Figure 18).

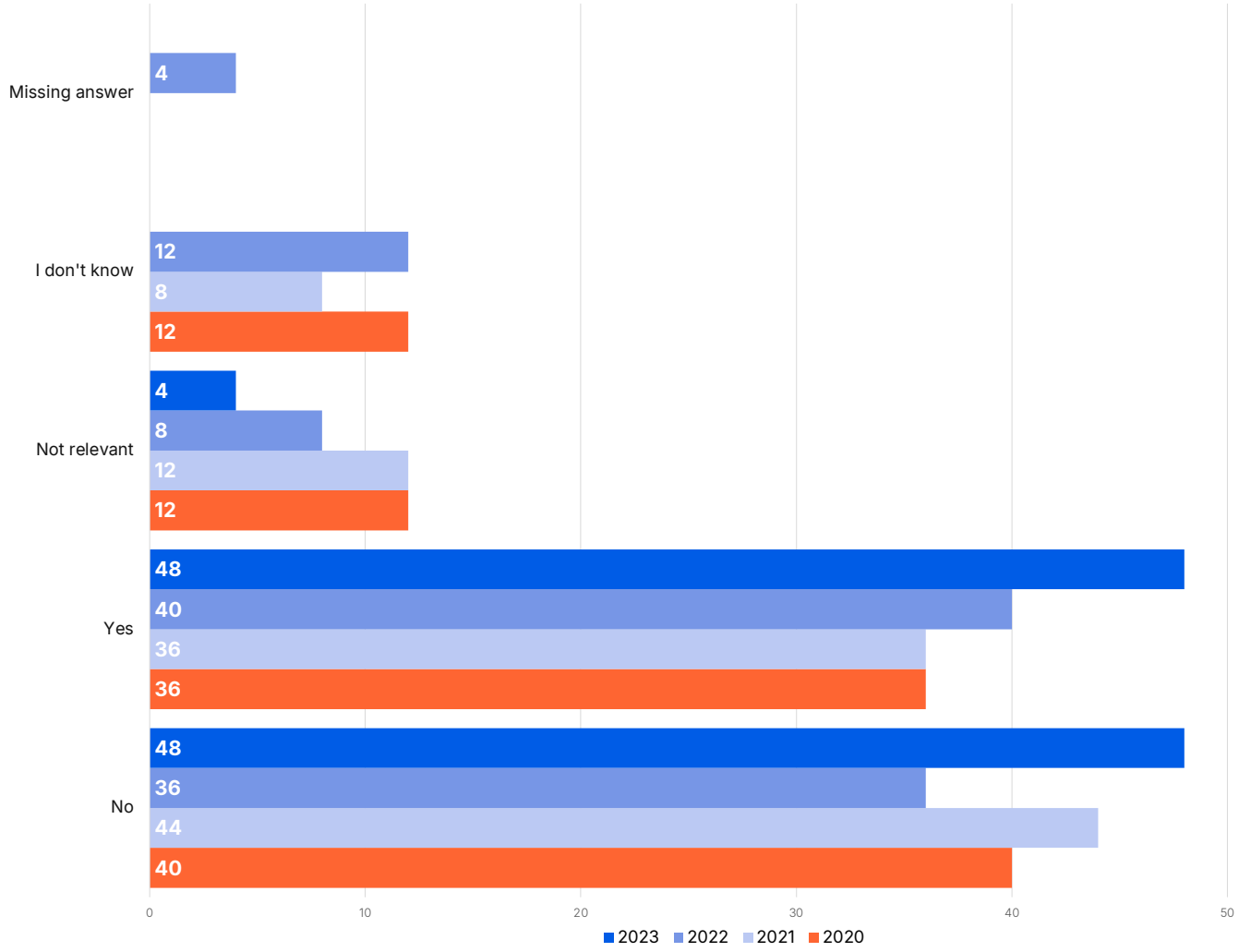


Figure 18. Is linkage-to-care for people who inject drugs achieved by a written protocol/guidelines? Think of an agreed protocol to refer clients, such as from a harm reduction service to other treatment and care **(%, n=25)**

Comparison of development in 25 cities during 2020-2023: limitations for harm reduction organisations

When comparing the limitations faced by harm reduction organisations to address HCV in the 25 cities from 2020 to 2023, there is a noticeable deviation in 2022, with fewer limitations than in other years (Figure 19).

This might be explained by temporarily increased operating powers at the late phase of the COVID-19 pandemic.

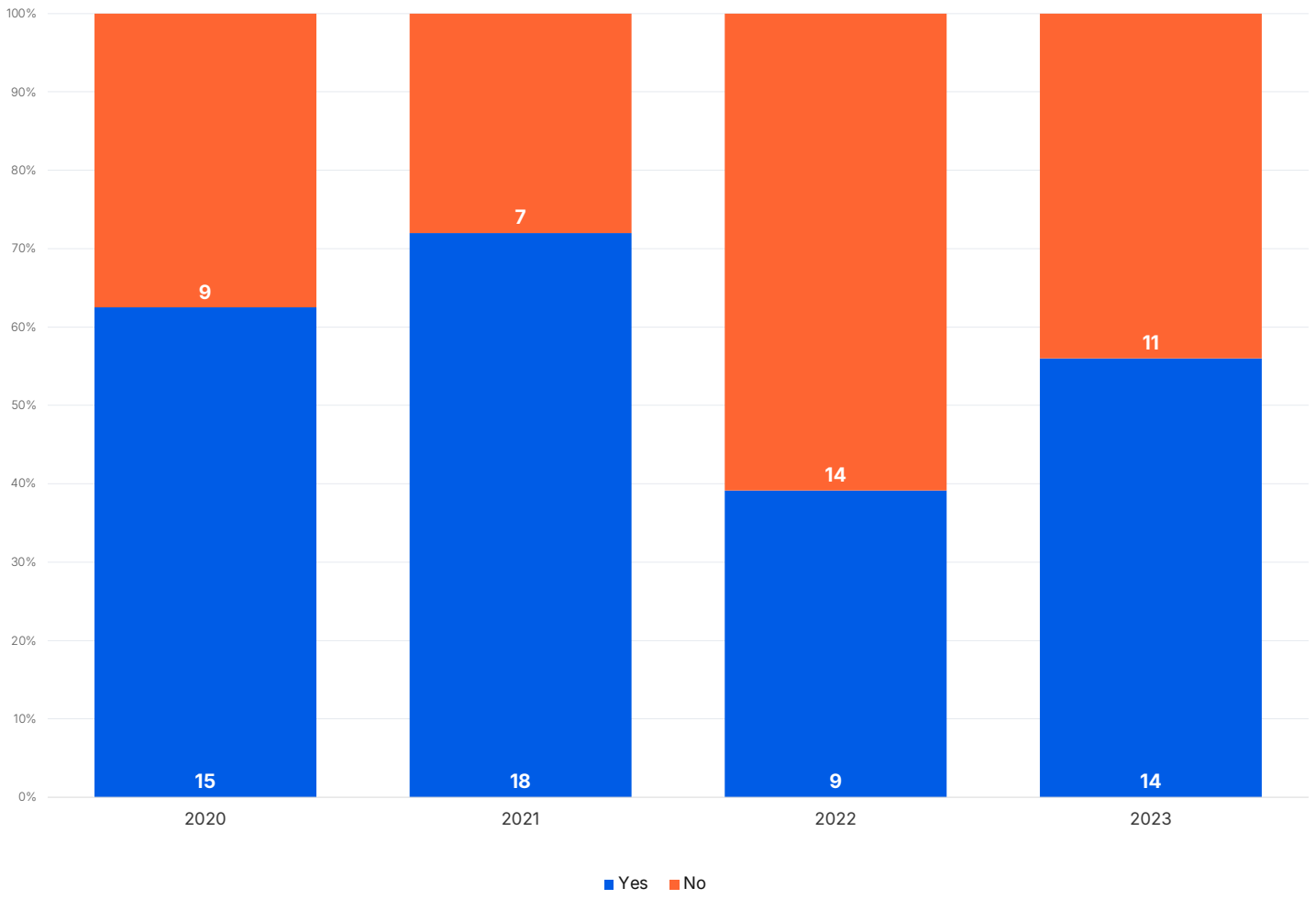
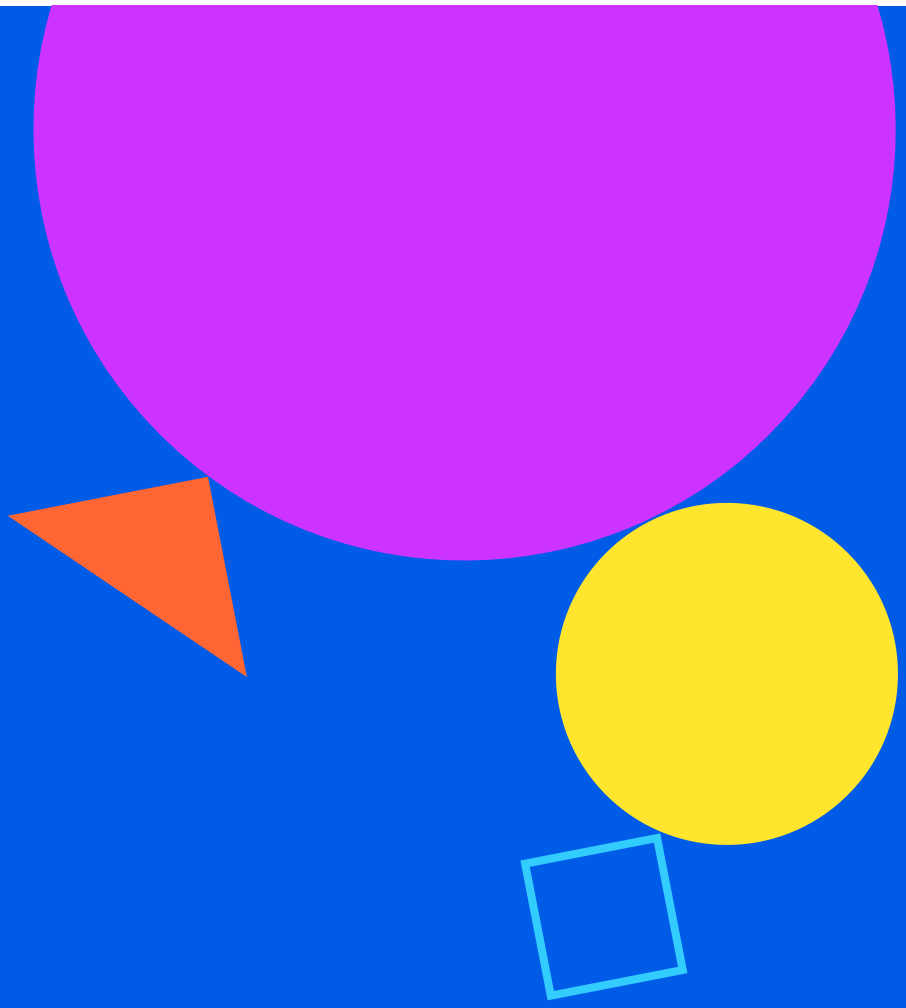


Figure 19. Are there limitations for harm reduction organisations in addressing HCV in your city **(%, n=25)**



3

Conclusions

HCV elimination by 2030, as suggested by WHO, is proceeding at different speeds in Europe. In some countries it appears plausible, whereas in several countries there is still a lack of economic support, political advocacy, and insufficient infrastructure. The evidence supports the efficacy of micro-elimination among key populations, such as people who inject drugs (Maticic, Lombardi et al., 2020). In the spring of 2023, C-EHRN invited civil society organisations (CSOs) from 35 European cities in 32 countries to complete a survey on the availability of, and access to, interventions that constitute the HCV continuum-of-care, specific for people who inject drugs. The data provides valuable evidence to assess where effective actions have been sufficiently implemented to eliminate HCV among people who inject drugs.

This year's monitoring data suggests that in many cities and countries, there are still significant barriers to scaling up services. These barriers include restrictions related to DAAs and the costs associated with testing and treatment. Additionally, there has been limited progress concerning the simplification of care pathways, task shifting, and improving community access.

Given the variation in respondent numbers across years and cities, direct year-to-year comparisons have been difficult to make in previous years. This year, however, we have also presented some comparable figures for those 25 cities that have answered the survey every year between 2020 and 2023. At a general level, the interpretation from four years development is that the positive trajectory of development has been re-established after the pandemic and related restrictions in services and other activities. Although there has been clear improvement in many cities and countries in policies and practices to eliminate HCV among people who inject drugs, overall progress remains insufficient across Europe.

The more detailed results, and the policy recommendations based on them, are summarised in Boxes 3 and 4, below.

Box 3

Main Results

In total, 35 cities representing 32 countries answered questions on HCV.

Guidelines on HCV testing and treatment for people who inject drugs exist in most countries and, where they exist, they mostly have a positive impact in terms of access to testing and treatment.

HCV guidelines pertaining to people who inject drugs are still missing from two countries.

DAAs are accessible in all cities, and mostly without restrictions. When restrictions occur, these are mostly related to advanced state of liver fibrosis, active drug use, and enrollment on OAT.

Stigma and discrimination towards people who inject drugs happens at different points of HCV care, with the most common occurrences at prison settings, general practitioners', gastroenterology and infectious disease clinics, as well as in drug treatment.

Most cities do not have monitoring for stigma and discrimination against people who inject drugs in HCV treatment.

In slightly more than half of the cities, DAA treatment is reimbursed without restrictions, also for people without health insurance.

HCV testing is freely available in all partaking cities, but in 13/35 cities it is available only at specific testing points.

In the majority of cities, a prescription is not needed for HCV testing, although in 7/35 cities it is required "sometimes". A prescription is always necessary only in two cities.

Testing for active HCV infection is conducted in various settings, with the most common still being infectious disease clinics (31/35 cities). In almost half of responding cities (45.7%), confirmatory HCV testing can also be conducted in harm reduction services.

When comparing the settings for confirmatory testing for active HCV infection during the four years (2020-2023) in 25 cities that have responded to this question every year, with the exception of prisons and pharmacies, there is a decline in the proportion of cities testing from 2020 to 2023 in every other setting.

Guidelines for clinical follow up after HCV diagnosis and observation of individuals who use drugs with HCV (aimed at averting liver damage and preventing liver cancer) were present in 22/35 cities (62.9%) but in eight cities (22.9%) they were not.

People who inject drugs can have DAA treatment at infectious disease clinics (29/35 cities) and gastroenterology clinics (25/35 cities). DAA treatment is available in drug treatment services in 18/35 cities, in prisons in 21/35 cities, at harm reduction services in 12/35 cities, and also at GPs in 12/35 cities.

Over the years from 2020 to 2023, there has been a trend in the distribution of treatment locations for people who inject drugs with access to DAAs. Infectious disease clinics consistently have the highest number of places for treatment. Gastroenterology clinics also have a significant role in providing treatment, with the second-highest number. For treatment within prisons, there is a notable increase from 2020 to 2023.

There are varying prescription rights for DAAs among different medical professionals across the European cities: in 2023, infectious disease specialists had prescription rights in 30/35 cities, and gastroenterologists/hepatologists in 29/35 cities; General Practitioners are allowed to prescribe DAAs in 11/35 cities and nurses in 3/35 cities.

HCV awareness campaigns improved in 10/35 cities (28.6%), and the work on awareness raising remained consistent in over half of the cities (51.4%).

HCV testing services seemed to have improved in many cities, rebounding after the pandemic years. In 2023, almost half of the cities (48.6%) reported testing improvements, while 15/35 cities (42.9%) maintained the same standards as before. Importantly, none of the respondents observed negative trends in testing over the past year.

Regarding non-invasive diagnostic procedures like Fibroscan®, 8/35 cities (22.9%) noted improvement, while in the majority of cities (57.1%), these services remained unchanged.

Compared to the previous year, HCV treatment services improved in 14/35 cities (40%) and remained stable in 17/35 cities (48.6%). In Kyiv, in the midst of Russian aggression, HCV treatment experienced a decline.

There were limitations for harm reduction organisations in addressing HCV in almost half of the cities (48.6%). The most frequently mentioned limitations included the lack of funding (13/35 cities); lack of care integration with the healthcare system (13/35 cities); lack of staff (10/35 cities); and a lack of recognition and political support (both eight cities).

Box 4

Policy recommendations

Based on the 2023 monitoring results, the following policy recommendations seek to enhance HCV testing and treatment accessibility, reduce stigma and discrimination, and improve overall care for people who inject drugs across European cities.

HCV guidelines for people who inject drugs

All countries should be encouraged to develop comprehensive HCV guidelines specifically tailored to people who inject drugs.

Access to Direct-Acting Antivirals (DAAs)

Advocate for consistent and unrestricted access to DAAs for HCV treatment everywhere. Address any restrictions to ensure equitable access for people who inject drugs.

Reduction in stigma and discrimination

· Implement anti-stigma and discrimination campaigns, especially in HCV testing and treatment settings where they are most commonly encountered, such as prisons, GP offices, gastroenterology and infectious diseases clinics, and drug treatment facilities.

· Promote awareness and training programmes for healthcare providers to reduce discrimination against people who inject drugs during HCV care.

· Establish monitoring systems to regularly assess and address stigma and discrimination against people who inject drugs who have HCV.

Reimbursement of DAA treatment

Advocate for DAA treatment reimbursement without restrictions in all cities, including coverage for individuals without health insurance.

Access to HCV testing

· Ensure HCV testing is freely accessible, and work to expand low threshold testing points.

·Promote the availability of HCV testing in harm reduction services to facilitate early diagnosis and treatment.

· Continue the trend of diversifying treatment locations for people who inject drugs with access to DAAs, with a focus on expanding treatment within prisons, GPs', and harm reduction services.

Post-diagnosis follow-up and observation

Encourage the establishment of post-diagnosis follow-up and observation programmes in cities where they are lacking, with a focus on averting liver damage and preventing liver cancer in people who inject drugs with HCV.

HCV awareness campaigns

Support and expand HCV awareness campaigns to improve knowledge and understanding of the virus, its transmission, and prevention.

HCV testing services enhancement

Invest in the improvement of HCV testing services, ensuring they remain accessible and efficient, especially in the aftermath of the COVID-19 pandemic.

Non-invasive diagnostic procedures

Continue increasing access to non-invasive diagnostic procedures (Fibroscan®) to enhance the accuracy and efficiency of liver health diagnosis.

HCV treatment service improvement

Monitor and improve HCV treatment services, with particular attention to cities and countries experiencing a decline.

Support for harm reduction organisations

Address limitations faced by harm reduction organisations, including securing funding, integrating care with the healthcare system, and increasing staff resources. Advocate for recognition and political support for these organisations.

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C-EHRN Focal Points contributing to the HCV survey in 2023

Country	City	Organization	Main contact
Albania	Tirana	Aksion Plus	Besnik Hoxha
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Bulgaria	Sofia	Center for Humane Policy	Yuliya Georgieva
Cyprus	Nicosia	Cyprus National Addictions Authority	Evi Kyprianou
Czechia	Prague	SANANIM z.ú.	David Pesek and Jiří Richter
Denmark	Copenhagen	HealthTeam for the Homeless Copenhagen	Henrik Thiesen
England	London	Release	Shayla S. Schlossenberg
Estonia	Tallinn	OÜ ReCuro	Greete Org
Finland	Helsinki	A-Clinic Foundation & Ehyt Ry	Juha Sedergren and Kimi Kannussaari
France	Paris	Fédération Addiction	Marine Gaubert
Germany	Berlin	Fixpunkt e. V.	Astrid Leicht
Germany	Bielefeld	Drogenberatung e.V. Bielefeld	Jan-Gert Hein
Greece	Athens	Positive Voice	Marios Atzemis
Hugary	Budapest	Rights Reporter Foundation	Peter Sarosi
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Ireland	Dublin	Ana Liffey Drug Project	Tony Duffin
Italy	Milano	Fondazione LILA Milano	Lella Cosmaro
Italy	Rome	Forum Droghe	Antonella Camposegrana and Susanna Ronconi
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Malta	Malta	Harm Reduction Malta (Facebook page)	Karen Mamo
Moldova	Bălţi	The Union	Ala Latco
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Ukraine	Kyev	NGO Club Eney	Velta Parkhomenko
Wales	Newport	Kaleidoscope	Martin Blakebrough

Correlation

European Harm Reduction Network

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