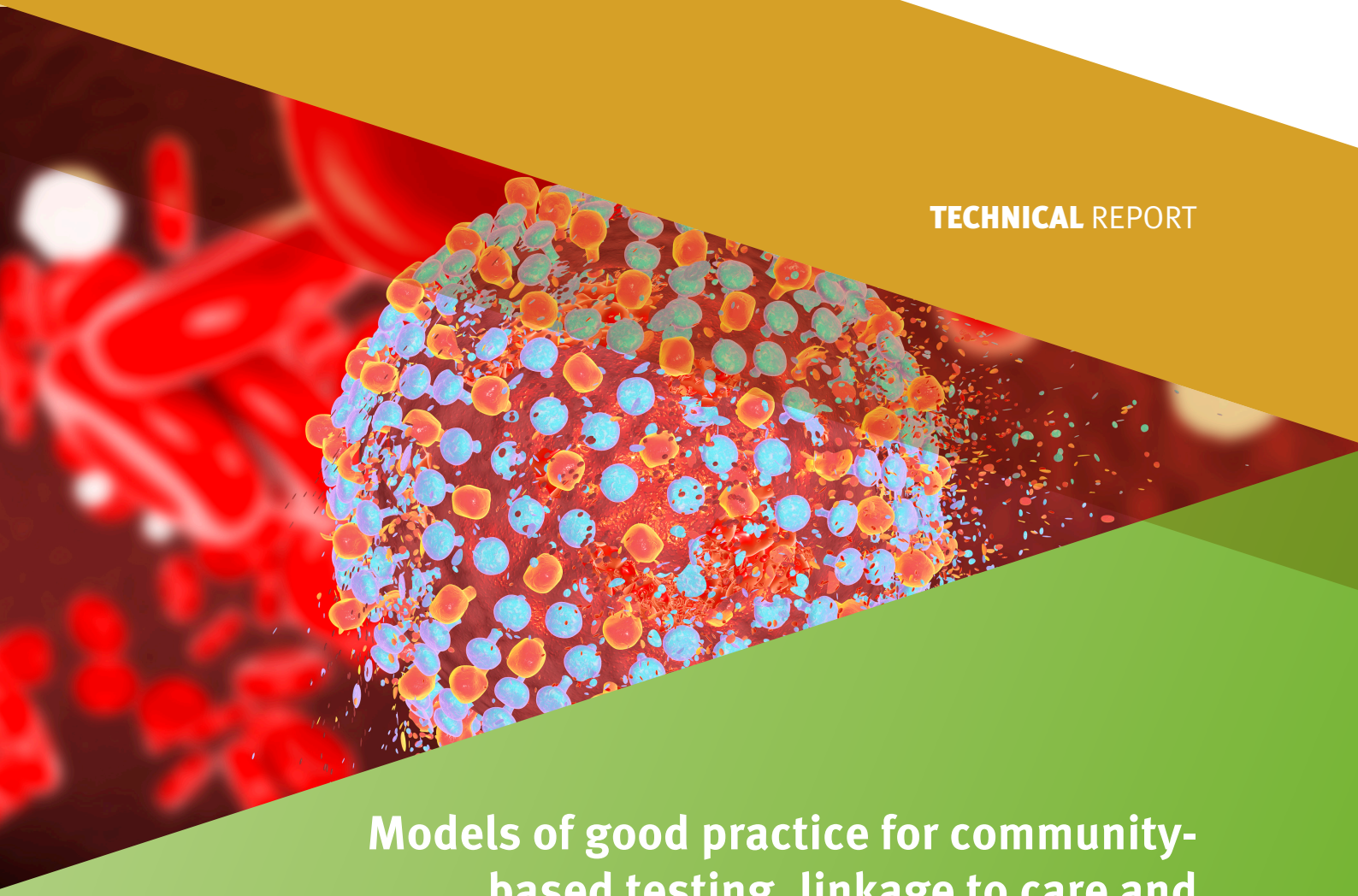

TECHNICAL REPORT

Models of good practice for community-based testing, linkage to care and adherence to treatment for hepatitis B and C, HIV, and tuberculosis and for health promotion interventions to prevent infections among people who inject drugs

From the package of technical documents published to accompany the joint ECDC and EMCDDA update of the guidance, 'Prevention and control of infectious diseases among people who inject drugs' (2023)

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Abbreviations

ADU	Active drug users
ALT	Alanine aminotransferase
ART/ARVT	Antiretroviral therapy (HIV)
AST	Aspartate transaminase
BBV	Blood-borne virus
cART	combined antiretroviral therapy
CD4	Cluster of Differentiation 4
CDC	United States Centers for Disease Control and Prevention
CI	Confidence interval
DAA	Direct-acting antivirals
DOT	Directly observed therapy
EEA	European Economic Area
EECA	Eastern Europe and Central Asia
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
GOEG	Gesundheit Österreich
GP	General practitioner
HIV	Human Immunodeficiency Virus
ITT	Intention-to-treat
MDR-TB	Multidrug-resistant tuberculosis
MSM	Men who have sex with men
NHS	National Health Service
NSP	Needle and syringe programme
ODN	Operational delivery networks
OST	Opioid substitution treatment
PLHIV	People living with HIV
PoC	Point of care
PSW	Peer support workers
RNA	Ribonucleic acid
STI	Sexually transmitted infection
SVR	Sustained virological response
TB	Tuberculosis
VL	Viral load

Glossary

Adherence to treatment

The extent to which a patient actively follows through with prescribed medical treatment and recommendations.

Cascade of care model

A model comprised of the key stages of care for people living with a particular disease. It can be adapted for different disease areas but is generally comprised of the following key stages: prevention, identification, treatment and recovery. It is used to guide the monitoring of outcomes and the tailoring of interventions accordingly. It is also called the continuum of care within the context of HIV/AIDS.

Community-based testing

Community-based testing is where voluntary HBV, HCV, TB and/or HIV testing occurs outside of healthcare facilities.

Linkage to care

The process that links a person newly diagnosed with an infectious disease to care, including medical treatment.

Low-threshold services/settings

Easily accessible and affordable, welcoming and supportive social and health services that remove barriers to care that are typically encountered in traditional healthcare systems.

Models of good practice

An intervention that has shown evidence of effectiveness in particular settings and is likely to be replicable in other situations.

Peers

People within a community with equal standing with each other, belonging to the same group and sharing a common experience. Peer support, which can occur informally or formally, refers to support provided and received by people who are peers.

Executive summary

Background

This collection of models of good practice of interventions to improve community-based testing, increase linkage to care and adherence to treatment for hepatitis B and C, HIV and tuberculosis and for health promotion interventions to prevent infections among people who inject drugs was conducted as part of the update of the joint European Centre for Disease Prevention and Control (ECDC) and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) guidance, 'Prevention and control of infectious diseases among people who inject drugs' (published in 2011). The purpose of this collection is to identify practice-based evidence for interventions with a documented impact implemented in real-life settings.

Methods

Within this collection, good practice is defined as an intervention or a package of interventions that has shown evidence of effectiveness in particular settings and is likely to be replicable in other situations.

A call for models of good practice was launched by ECDC and EMCDDA on 2 September 2020. A two-phase process (a call for expression of interest followed by the submission of models of practice using a structured online reporting form) was used, administered by the Austrian National Public Health Institute (Gesundheit Österreich, GOEG), and rolled out from September to November 2020.

A detailed reporting form has been developed for each of the four fields of intervention, including general information on the overall project, descriptive information on the intervention, data on sustainability, and evidence of the impact. Geographical coverage included the European Union (EU), the European Economic Area (EEA), the United Kingdom (UK), the European Neighbouring Policy (ENP) area, and the Western Balkans.

An assessment form was developed to standardise the selection process, based on a set of quality criteria adopted from the European Commission's Steering Group on Promotion and Prevention (SGPP) document [1]. This set of criteria included:

- inclusion criteria to assess the adequacy/relevance of the intervention to the overall aim of the call;
- core criteria to consider whether the intervention was successful;
- qualifier criteria to assess whether the model of practice contains elements that are relevant for other settings, ensure sustainability, etc; and
- specifier criteria to allow categorisation by settings or sub-populations (no impact on the assessment of the relevance of an intervention).

The selection process of submitted interventions followed a two-phase process. In the first phase, an internal pre-assessment was conducted by GOEG focusing on inclusion and core criteria. In the event of any missing or unclear information, follow-up input was requested from the submitting authors. Submissions meeting the inclusion and core criteria were presented to the Expert Panel. Experts were invited to assess the qualifier criteria for four submissions by scoring transferability, sustainability, participation, and inter-sectoral collaboration. The score for each criterium was between 0 (not applicable) and 5 (fully applicable). To qualify as a model of good practice, a total score of 12 out of a maximum of 20 had to be reached.

Results

In the first phase of the call, 31 institutions from 16 countries expressed interest. In the second phase, 23 models of practice were submitted, using an online reporting form: seven submissions covered interventions to improve community-based testing, nine addressed interventions to increase linkage to care, five addressed interventions to increase adherence to treatment, and two submissions referred to health promotion interventions to prevent infections among people who inject drugs. Following the pre-assessment phase, 19 submissions qualified for expert panel review. Seventeen of the 19 submissions were selected as models of good practice. The 17 interventions were implemented under 12 different project/framework programmes in Austria, Belarus, Italy, Norway, Portugal, the Republic of Moldova, Spain, the UK, and one cross-national project carried out in Ireland, Romania, Spain, and the UK. Most of these projects addressed hepatitis C (10) as well as HIV (7), with HBV covered in four projects and TB in three projects. Nearly all projects addressed more than one infection. Those covering only one infection focused solely on the HCV care cascade.

Among the 12 projects/programmes from which the models of practice emerged, seven integrated a peer involvement approach to either enhance community-based testing (e.g. outreach peer support, peer-to-peer recruiting, involvement in point-of-care testing) and/or to increase linkage to care (e.g. peer navigators supporting referrals, outreach tracing of those not in care) and/or to increase adherence to treatment (e.g. keep regular contact during treatment). Another approach that was often used (5/12) was the integration of nurses in

the treatment cascade. In addition, more than half of the projects used a multidisciplinary approach and put effort into the cooperation between drug services and specialised healthcare services, often using a low-threshold approach, in particular to increase linkage to care. A synopsis of the 12 models of practice by type of intervention, settings, and people who inject drugs subpopulation is presented in Annex 1.

Conclusions

This collection of models of good practice describes interventions and approaches currently being used successfully by European countries to address the care cascade of infections among people who inject drugs. The submitted models of good practice indicate a scarce availability of good quality data to measure practice-based evidence. It also illustrates the large amount of preparatory and supporting work (e.g. preparedness of care environment and of clients) that is needed to quantify the effectiveness of interventions. This is of particular relevance in hard-to-reach populations such as people who inject drugs.

The models of good practice presented here highlight the need for the programmes to be adjustable and adapt their approaches to national legal frameworks to existing healthcare and drug services and to the particular needs of the people who inject drugs populations aimed at being reached. Factors such as peer involvement, trust, and convenience to patients, community or low-threshold approaches covering a broad spectrum of patient needs can be seen as successful approaches. Systematically assessing the effects of such interventions warrants more attention in a future research agenda.

1. Background

In 2020, ECDC and EMCDDA initiated the update of their joint guidance on 'Prevention and control of infectious diseases among people who inject drugs' (2011) [2]. In the 2011 guidance document, seven key interventions were recommended, based on scientific evidence combined with expert opinion and models of best practice of prevention within the EU/EEA. The guidance was supported by two technical reports [3,4] summarising the evidence for effectiveness of needle and syringe programmes (NSP) and of drug treatment for preventing hepatitis C, HIV, and injecting risk behaviour. A stakeholder survey carried out in 2018 by ECDC and EMCCDA suggested the need to update some of the guidance's key recommendations and consider emerging topics and public health concepts. ECDC and EMCDDA initiated the update process in 2019 and commissioned an update of the evidence base and new collection of evidence on interventions that can improve linkage to care and adherence to treatment of infections of people who inject drugs.

The searches for evidence in the peer-reviewed literature were supplemented with a call for models of practice launched by the two agencies, with technical support from GOEG. The aim of the two-phase call was to identify practice-based evidence from interventions implemented in real-life settings and with a documented impact on prevention of infections among people who inject drugs.

This report summarises the methods of the call for models of practice (Chapter 2), describes the selection process of submissions guided by a set of quality criteria (Chapter 3) and presents those submissions that, after critical assessment by an expert panel, qualified as models of good practice (MoGP) (Chapter 4).

2. Collection of models of good practice

In order to identify interventions that can be presented as models of good practice, a two-phase call was launched by ECDC and EMCDDA in regard to several areas of interventions (see Table 1).

Table 1. Areas of interventions for models of good practice collection and research questions

Area of interventions	Research question
A – community-based testing	Which models of community-based testing proved effective for prevention or reduction of infections among people who inject drugs?
B – linkage to care	Which models of practice proved to increase linkage to care for infections among people who inject drugs?
C – adherence to treatment	Which models of practice proved to increase adherence to treatment for infections among people who inject drugs?
D – health promotion	Which health promotion messages (or other types of education interventions) have been successful for prevention of infections among people who inject drugs?

Infections of interest were hepatitis B (HBV), hepatitis C (HCV), HIV, and tuberculosis (TB). Geographical coverage included the EU/EEA and the United Kingdom (UK), the European Neighbouring Policy (ENP) area, and the Western Balkans. At the time of the call the UK was in the transition period following the withdrawal agreement and could be included in the call although not a European Union Member State [5].

The two-phase call, administered by GOEG, was rolled out from September to November 2020. The EU Survey tool was used to collect submissions of models of practice based on structured questionnaires developed by GOEG.

Phase 1: Call for expressions of interest to report models of practice

During phase 1, a call for expression of interest for submitting models of practice targeting people who inject drugs in relation to the four areas of interventions (A to D) was sent out by ECDC and EMCDDA to infectious disease- and drug-treatment-red researchers and/or networks, as well to individual experts. The overall list comprised 20 networks as well as 50 researchers, identified through a literature search. The call included an invitation for an online registration of interest through the EU Survey tool.

Table 2. Number of expressions of interest recorded by area of intervention and infection*, phase 1 of the call

	Area of intervention	Number of expressions of interest
A	Interventions to improve community-based testing for people who inject drugs	30
B	Interventions to increase linkage to care for people who inject drugs	25
C	Interventions to increase adherence to treatment for people who inject drugs	21
D	Health promotion interventions to prevent infectious diseases	20

** Note: some interventions address more than one infection.*

In total, 96 expressions of interest were registered, from 31 responding institutions from 16 countries: Austria, Belarus, Bosnia-Herzegovina, Croatia, Cyprus, Czechia, Germany, Greece, Iceland, Ireland, Italy, the Netherlands, Norway, Portugal, Spain, and the United Kingdom, as well as one EU-funded project.

Phase 2: Online submission of a model of practice guided by structured reporting forms

In phase 2, respondents who expressed interest in submitting a model of practice in phase 1 were contacted by GOEG and provided with a link to an online reporting form. The reporting form was specific to each area of intervention (A to D) and consisted of two sections. Section 1 collected general information on the project/programme or other type of general framework under which the intervention has been implemented. Section 2 collected specific information on the intervention, including a description of it as well as data

documenting its impact and sustainability. Interested parties could fill in several reporting forms if more than one intervention were implemented within one general project/programme.

The call for expression of interest as well as the four online reporting forms are presented in Annexes 2-6 of this document.

A total of 23 submissions were received during phase 2 of the call in October 2020 (Table 3).

Table 3. Number of submissions of models of practice received by area of intervention and infection*(phase 2) N= 23

	Area of intervention	Number of submissions	Infection addressed: HIV HCV HBV TB			
A	Interventions to improve community-based testing for people who inject drugs	7	6	7	2	3
B	Interventions to increase linkage to care for people who inject drugs	9	2	7	1	1
C	Interventions to increase adherence to treatment for people who inject drugs	5	2	4	1	1
D	Health promotion interventions to prevent infectious diseases	2	2	2	2	0

** Please note that some interventions address more than one infection.*

3. Selection of models of good practice

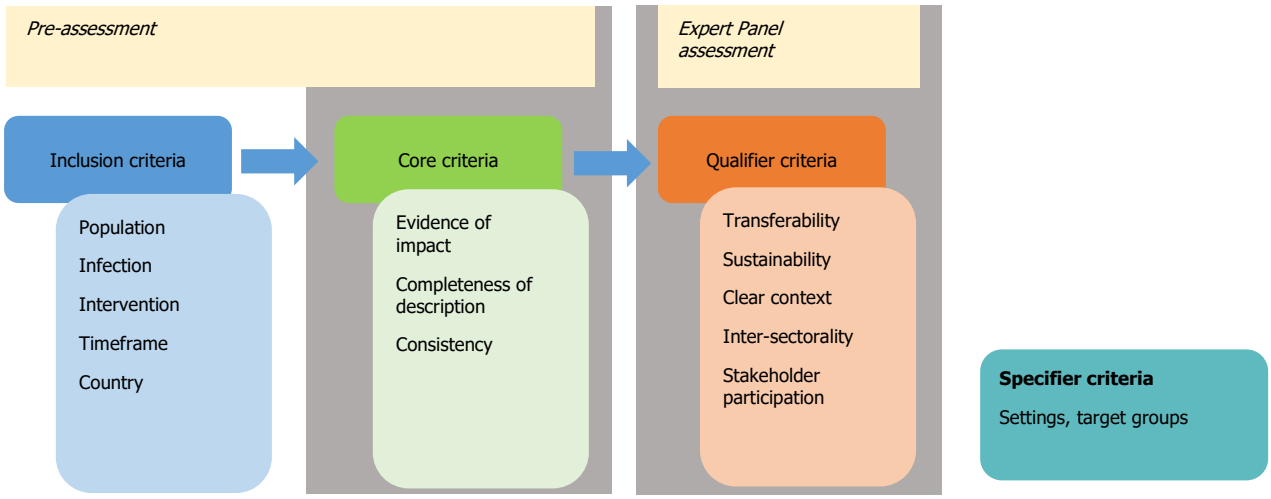
When submitting models of practice through the EU Survey tool, the authors were required by the structured format to offer detailed information on the context, process, and outcomes of the intervention. They were made aware in advance of the importance of reporting/documenting the impact of the intervention.

To standardise the selection process of models of good practice among the received submissions, an assessment form was developed by GOEG in consultation with ECDC and EMCDDA, including a set of quality criteria. The assessment form is presented in Annexes 7 and 8 of this document. The quality criteria were adapted from the European Commission's Steering Group on Promotion and Prevention (SGPP) document [1]. The following three sets of criteria were included in the standardised evaluation form (Figure 1):

- Inclusion criteria – defined as criteria to assess the adequacy/relevance of the intervention to the overall aim of the call (e.g. population is people who inject drugs, intervention is any of A to D, infection is any of HIV, HBV, HCV, TC);
- Core criteria – considering whether the intervention was successful/had a documented impact; and
- Qualifier criteria – assessing whether the model of practice contains elements that are relevant for other settings, ensures sustainability (funding, type of project, policy support) and includes participation (peer involvement) and inter-sectoral collaborations.

Specifier criteria were developed to allow categorisation by settings or sub-populations but had no impact on the overall assessment of the relevance of an intervention (see the synopsis in Annex 1).

Figure 1. Process of selecting submissions for models of good practice



Inclusion criteria and core criteria were part of the pre-assessment phase of the evaluation and were assessed by GOEG. Submissions that met these two criteria were selected for review by an expert panel that was convened by ECDC and EMCDDA for the update of the guidance on prevention and control of infections among people who inject drugs (2023).

Pre-assessment by GOEG – inclusion and core criteria

In the first phase, the submissions of models of practice were assessed by GOEG against the inclusion criteria and the core criteria (Figure 1). During this phase, authors were contacted and asked to provide missing information or further details, particularly when the evidence of an impact was insufficiently described.

A total of four interventions, all relating to linkage to care, were excluded due to double reporting, the primary target group not being people who inject drugs or follow-up input missing after request. Nineteen interventions were selected for the next phase.

Assessment by Expert Panel members – qualifier criteria

In the second phase, the 19 submissions that met the inclusion and core criteria were presented for the Expert Panel's assessment. The Expert Panel members were invited to assess four submissions each.

Phase two of the evaluation covered the qualifier criteria, which assessed whether the submission covered elements that are relevant for transfer to other settings, ensured sustainability and included participation and inter sectoral collaboration. Further explanations of the criteria are as follows:

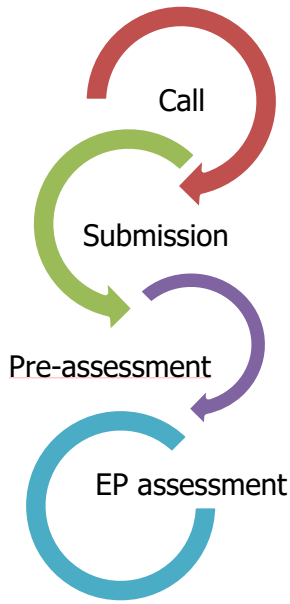
- Transferability covers legal aspects, cost, coverage;
- Sustainability is defined as funding, type of project, policy support/linkage;
- Participation includes involvement of peers and other population groups; and
- Inter-sectoral collaboration includes the involvement of key partners and sectors within the development and/or delivery of the intervention.

The score for evaluating these criteria ranged from 0 to 5 (0=not applicable; 5=fully applicable). To qualify as a model of good practice, a total minimum score of 12 had to be reached.

In total, 12 experts contributed to this evaluation/assessment of submissions. Seventeen of the 19 submissions finally qualified as models of good practice and are presented in this technical report. An overview of selected submissions is provided by type of intervention in Chapter 4 (see Tables 4, 5, 6, and 7).

Contributing experts are listed in the acknowledgments of this report.

Figure 2. Overview of the call for models of practice and selection of models of good practice



Phase 1: call for expression of interest
- In total, 96 expressions of interest were received
- 31 responding institutions from 16 countries

Phase 2: online submission
- Guided by a structured reporting form
- Total number of submissions received: (A)=7; (B)=9; (C)=5; (D)=2

Selection step 1: pre-assessment by GOEG
- Quality/completeness criteria: inclusion criteria and core criteria;
- Total number of submisions pre-selected: (A)=7; (B)=5; (C)=5; (D)=2

Selection step 2: Expert Panel assessment
- Qualifier criteria
- Total number of submissions selected as models of good practice: (A)=6; (B)=5; (C)=4; (D)=2

4. Qualified models of good practice

A. Interventions to improve community-based testing for people who inject drugs

Table 4. Overview of models of good practice to improve community-based testing for people who inject drugs

	Name of project	Affiliation	Country	Infection(s) addressed
A.1	Accelerating the TB/HIV response for key populations in EECA* cities	Union for HIV Prevention and Harm Reduction	Republic of Moldova	HIV/AIDS, TB
A.2	REACH-U – Point-of-care hepatitis C antibody and RNA testing and linkage to care to enhance uptake of treatment in outreach settings	CRESCER - Associação de Intervenção Comunitária	Portugal	HCV
A.3	Improvement of HIV testing rates and involvement of people who inject drugs in dispensary observation at prevention points in Minsk	Belarusian Public Association 'Positive Movement'	Belarus	HCV, HIV/AIDS
A.4	Hepatitis C Bus (HCV-bus)	Norwegian Directorate of Health	Norway	HCV, HIV/AIDS
A.5	Mobile Outreach Programme	Associação Ares do Pinhal	Portugal	HBV, HCV, HIV/AIDS, TB
A.6	Find & Treat: Peer-led Blood-Borne Virus Community Outreach Project	Find & Treat, UCLH NHS Trust/Institute of Global Health, UCL**	United Kingdom	HBV, HCV, HIV/AIDS, TB

** Eastern Europe and Central Asia*
*** UCL(H) = University College London (Hospitals); NHS = National Health Service*

A.1 Accelerating the TB/HIV response for key populations in cities in Eastern European and Central Asian countries

Author Ala Iatco
Affiliation Union for HIV Prevention and Harm Reduction
Country Republic of Moldova
Infections addressed HIV/AIDS, TB

General information on the project/programme

In November 2018, a regular programme started with the aim of improving TB/HIV treatment for key groups in the municipality of Bălți in Moldova, which has significantly higher HIV and TB prevalence rates than the national average. The implementation of the initiative was mainly driven by this high prevalence of HIV and TB, as well as a high mortality from HIV/TB co-infection in the municipality. People in opioid substitution treatment (OST), young people who inject drugs, partner contacts. and sex workers were defined as specific sub-populations of current people who inject drugs in this peer-led intervention, which was implemented in low-threshold and OST settings as well as in outreach programmes. The project used active peer involvement to recruit the target group, namely respondent-driven-sampling methodology.

Background

In comparison to the national level, the incidence and prevalence of HIV infection in Bălți municipality are up to 3.5 times higher. The number of new cases in Bălți municipality, unlike in the rest of the country, seems to stabilise. The HIV epidemic is concentrated among three population groups: people who inject drugs, SW, and men who have sex with men (MSM). Among people who inject drugs in Bălți municipality, HIV prevalence declined from 40% in 2010 to 15% in 2020, which underlines the impact of harm reduction programs.

The TB-HIV co-infection rate in Bălți municipality ranged between 16.5% and 25.5% over the previous three years (2016-2018), which was twice the national level. Nationally, almost every fifth person who died from the progression of tuberculosis was HIV-positive; in Bălți, more than half were living with HIV. It is therefore particularly important to put more effort into achieving the national target of reducing the HIV co-infection rate

among TB cases to 5%. Most people with TB-HIV co-infection are at high risk for active tuberculosis due to their precarious social/living situation. This indicates the need for a multi-pronged approach to TB-HIV co-infection, including in particular improved detection.

Goal and description of the intervention

The general goal of the intervention is the implementation and evaluation of the effectiveness of optimised HIV/TB testing and social support using a case management approach in Bălți municipality. It should help to overcome the reluctance of key populations to access available medical institutions and diagnostic services due to stigma, discrimination, fear of social visibility, reduce long waiting times for test results and increase effective HIV/TB detection strategies in resource-limited settings.

The following measures were implemented:

- Optimised HIV testing, the use of rapid HIV tests for people who inject drugs and their partners and of a TB screening tool as well as referral to ART or TB treatment for clients with a positive test/screening result;
- Community involvement (Community Initiated Treatment Intervention): outreach work by a peer consultant providing direct social support for each specific client prior to the appointment for ART and anti-tuberculosis treatment;
- Respondent-driven sampling approach for peer-to-peer recruiting: using a coupon system as part of the testing strategy procedure.

Results and evidence of impact

Results of internal routine monitoring and internal evaluation show that the use of the respondent-driven sampling approach led to a relatively high detection rate of new cases. Generally, it has been reported that the intervention optimised the use of resources, lowered the access threshold to prevention services for the target population, and shortened the time interval between detection and treatment initiation. The submitter assumes that - with a higher level of coordination effort - this strategy could potentially be used for micro-elimination or for early detection of disease clusters/outbreaks.

Table A.1. Indicators and results

Indicator and results for HIV	Total number
Number of people who inject drugs tested	1 993
Number of new cases diagnosed	78
Number of clients entered in medical records/database	44
Number of clients started ART	34
Indicator and results for TB	**Total number**
Number of people who inject drugs evaluated for TB based on a screening questionnaire	1 964
Number of people who inject drugs with positive screening	133
Number of people who inject drugs diagnosed with TB	7
Number of people who inject drugs started TB treatment	6

In addition, effective models for integrating HIV and TB services for vulnerable groups have been introduced, both in NGOs as well as in medical institutions. Methadone substitution therapy became an integrated part in phthisio-pulmonary services for patients with opioid use receiving anti-tuberculosis treatment. Chemoprophylaxis of tuberculosis with isoniazid has been integrated into drug treatment service for patients on opioid substitution therapy.

The number of TB diagnoses in the first eight months of 2019 in Bălți municipality increased about one third compared to 2018. The identified cases were in the initial stage of TB disease (destructive forms 25% compared to 37%), which indicates that screening resulted in earlier detection. Another fact that may indicate an intensification of screening measures is an increase in the number of cases of TB detection from contact persons/focal contact (from 7.9% to 17.8% and 18.6%).

The prevalence of TB/HIV co-infection cases decreased from 24.7% (2018) to 22.9% (until 08/2019). During this implementation period (11/2018-08/2019), treatment outcomes were improved both in cases with susceptible TB and in cases with MDR-TB, including TB/HIV co-infection.

Transferability and sustainability of the intervention

The submitter considers this intervention as transferable, further information is available from www.uorn.md (Moldovan only).

The intervention has been established as a two-year programme funded by a specific regional/local budget and is directly linked to the National programme for HIV/AIDS and STIs prevention and control for 2016-2020, in particular to the first objective of the national programme, 'HIV prevention in at-risk groups by strengthening HIV testing'.

The submitter considers the mechanism of practical interaction and cooperation between local authorities, medical, social institutions and non-governmental organisations in the implementation of HIV/TB programmes in Bălți municipality as a main factor for success. In addition, recruiting for testing through peer counsellors had a positive impact on the outcome of the intervention.

Participation and inter-sectoral collaboration

Relevant partners in the development of the initiative were public health authorities (Health Department of the City Hall of Bălți municipality), healthcare providers (TB Hospital, Infectious, Narcological Service of the Republican Clinical Hospital in Bălți), as well as peers. Relevant partners in delivery of the activities were drug treatment providers, harm reduction service providers and peers. The Alliance for Public Health (Alliance Ukraina) was also a key partner.

A.2 REACH-U: Point-of-care hepatitis C antibody and RNA testing and linkage to care to enhance uptake of treatment in outreach settings

Author	Christiana Merendeiro
Affiliation	CRESCER – Associação de Intervenção Comunitária
Country	Portugal
Infection addressed	HCV

General information on the overall project/programme

CRESCER is a local low-threshold service, providing outreach services for approximately 2 000 PWUD per year, including 500 with recent injecting drug use, operating daily in urban areas of Lisbon that have high levels of drug consumption.

Barriers for attending specialist-based appointments in hospitals have led to suboptimal RNA testing and uptake of HCV therapy in an area with a high prevalence of HIV infection in people who inject drugs. In order to increase involvement in HCV care cascade, CRESCER initiated the pilot project 'REACH-U' in August 2020, which is implemented in low-threshold settings, outreach programmes (shelters) addressing current and former people who inject drugs with a specific focus on people in OST, migrants/asylum-seekers, MSM and youth who inject drugs (15-24 years). The project will continue until December 2022.

Details on the 'REACH-U' initiative to increase linkage to care are provided in B.3 and to increase adherence to treatment in C.3.

Background/rationale

Approximately 25 000 people were living with chronic HCV infection in Portugal in 2019. Most cases of HCV infection occur among people who inject drugs [6,7]. Among current people who inject drugs, the proportion of people living with HCV infection is estimated to be 66%. Among people in outreach, the prevalence varies between 18% (new participants), 37% (readmitted participants) and 79%–82% (people who have a history of injecting drug use) [8].

Since October 2018, CRESCER has been running a point-of-care (POC) HCV antibody testing combined with nursing and peer-based outreach intervention to enhance HCV testing and treatment among vulnerable groups. The intervention is aiming to meet socially isolated people who inject drugs in their own environment (e.g. areas with high levels of drug consumption), who refuse to leave the neighbourhoods and do not access other health services, including low-threshold or outreach services, e.g. opioid substitution treatment, mobile testing units or shelters. Between October 2018 and July 2020, 142 participants were enrolled. Overall, 37% (52 of 142) were HCV antibody positive and referred for specialist assessment. Only 37% (19 of 52) attended a specialist appointment. Among the 10 people with detectable HCV RNA, 40% (n=4) initiated treatment.

In August 2020, CRESCER implemented the pilot project REACH-U to enhance HCV testing and treatment uptake and began to implement HCV RNA testing outside of clinics in areas where the target population is located.

Goal and description of the intervention

The overall goal was to intensify HCV antibody and RNA testing efforts. Target populations include PWUD and other vulnerable populations, such as people without housing, asylum-seekers and migrants, with whom CRESCER works in related projects. In the future, this initiative is intended to integrate other low-threshold and outreach services, like shelters.

To enhance HCV testing, REACH-U is providing POC HCV testing and peer-based outreach. Participants have finger-stick blood samples collected on-site for HCV antibody and HCV RNA testing, an intervention simple to perform in an outreach context and applicable for people who inject drugs with difficult venous access. In addition, the intervention includes a participant-administered survey. HCV RNA test results are available on the same day. Participants are notified by text message (if possible) or contacted by a team member, who provides the outcome of the results.

Results and evidence of impact

The following impact indicators have been defined for community-based testing:

- proportion of participants who engage in HCV antibody testing;
- proportion of participants who engage in HCV RNA testing;
- proportion of participants who test HCV RNA positive; and
- proportion of participants with an increase in knowledge about HCV prevention.

A participant-administered survey will be conducted at the beginning and at the end of each individual participation. A non-randomised trial is planned to evaluate this intervention. In addition, an activity report to funding bodies will be produced.

No monitoring data have been reported due to the recent implementation of the pilot project REACH-U in August 2020. Although effectiveness could not be documented at the time of submission, the general consensus of the Expert Panel was to include the pilot project as a relevant model of intervention.

Transferability and sustainability of the intervention

The submitter considers the initiative as transferable to other national harm reduction and/or outreach services and prisons, if the political will, as well as appropriate flexibility of healthcare services are ensured. Existing harm reduction service approaches is a pre-condition of implementing this intervention in other countries.

REACH-U is conceptualised as a pilot project and funded by specific national and regional funding as well as co-funded by a pharmaceutical company. The work of REACH-U is directly linked to the Portuguese national programme for viral hepatitis, 2017 report 'Programa nacional para as Hepatites Virais'.

In order to sustain the intervention, the submitter identifies a need in development of outreach work and guaranteed outreach workers specialised training. Flexible procedures based on harm reduction approach need to be implemented and a good collaboration with the healthcare system needs to be ensured to facilitate access to appointments and treatment for people who inject drugs. The implementation of peer navigators is also considered as crucial for the sustainability of the intervention.

Furthermore, REACH-U indicates the establishment of public and private collaborative partnerships, advocacy campaigns that involved inviting public and private institutions to the field and the constant search for public and private financial support as core for the success of the intervention.

Participation and inter-sectoral collaboration

Peer workers have been relevant partners in the development of the overall initiative, by ensuring that the needs of the target population were met. CRESCER's multi-disciplinary team with long-time outreach working experience helped to identify barriers to community-based testing and interventions, and to develop strategies to overcome challenges. Gastroenterology experts has been involved in terms of clinical and research advice and a pharmaceutical company in terms of clinical advice.

Relevant partners in the delivery of overall REACH-U activities are peer navigators to enhance participation in HCV screening and facilitate linkage to care and treatment and prevention of re-infection, a specialised outreach harm reduction team (a nurse and a peer) as well as a medical doctor specialised in assessing treatment suitability and prescribing direct-acting antiviral (DAA) therapy from Gastroenterology Service – Santa Maria Hospital (Lisbon).

A.3 Improvement of HIV testing rates and involvement of people who inject drugs in dispensary observation at prevention points in Minsk

Author	Tatsiana Piachko
Affiliation	Belarus Public Association 'Positive Movement'
Country	Belarus
Infections addressed	HIV, HCV

General information on the overall project/programme

In 2018, the Belarus Public Association 'Positive Movement' NGO initiated a pilot project in Minsk aiming to increase the linkage to the medical system for diagnosis and treatment of HIV-positive clients at harm reduction points. This pilot, funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria, has been a stepping-stone in implementing a low-threshold approach in regard to HIV confirmatory testing and linkage to treatment services for people who inject drugs. The initiative is implemented at three low-threshold sites and one outpatient centre targeting current people who inject drugs, where – apart from needle and syringes provision (NSP) and other services – HIV and hepatitis C testing is provided free of charge.

Details on the BPA 'Positive Movement' initiative to increase linkage to care are provided in B.1.

Background/rationale

In Belarus, the standard algorithm for laboratory diagnosis of HIV infection in patients over the age of 18 months is regulated by the Clinical Protocol 'Diagnostics and treatment of patients with HIV infection' (Order of the Ministry of Health #715 as of 17.07.2018). It generally meets WHO recommendations for countries with low HIV prevalence (<5% of the population) and includes an HIV testing algorithm consisting of three tests, of which one is highly specific. These steps normally take place at different times in different healthcare settings, not guaranteeing the shortest possible time for obtaining the result. WHO recommendations on simplifying the testing pathway had not been implemented; solely medical institutions provided HIV diagnostics and treatment services and NGOs only carried out NSP programs and HIV rapid testing. Redundant testing stages are a barrier for drug users (as well as representatives of other vulnerable groups) to complete the pathway of confirming HIV infection, resulting in a high drop-out rate among people who inject drugs clients.

Prior to pilot project implementation, provision of NGO-based services related to diagnosis and treatment of HIV infection for people who inject drugs was considered inconceivable. Since 2014, the NGO 'Positive Movement' advocated the access to HIV diagnostics and treatment services 'at one point', not only in healthcare facilities, but also at harm reduction points. Years of advocacy efforts and work experience have led to the approval and support from partners in the implementation of the intervention.

Goal and description of the intervention

The overall goal is to increase the number of people who inject drugs who reach confirmatory HIV diagnosis after rapid testing at low-threshold harm reduction sites. Following a low-threshold approach, one stationary checkpoint and three mobile prevention checkpoints provide the following procedure:

1. Straight after receiving a positive HIV rapid test result, a member of the nursing staff conducts a dispensary database query to check whether a client has already been registered as HIV-positive.
2. If not registered yet, a nurse takes a blood sample from clients for transfer to a laboratory to confirm HIV infection. A mobile checkpoint delivers the samples to the laboratory.
3. If already registered, a nurse takes a blood sample for laboratory monitoring of CD4 cells and viral load from people who inject drugs living with HIV, who do not visit a hospital.
4. A nurse takes blood samples for laboratory diagnosis of viral hepatitis C. Samples are delivered by the mobile checkpoint.
5. At the stationary checkpoint, an infectious disease doctor and an epidemiologist are on duty to facilitate medical supervision.

Results and evidence of impact

The introduced measures have led to a significant increase of people who inject drugs accessing confirmatory testing for HIV (see Table A.3.1, indicated in bold letters) within the first three months of the project: between 9 and 10/2018 the number of people who inject drugs undergoing confirmatory HIV testing increased three times. Compared to the previous seven months in 2018 (when 14 confirmatory tests were recorded), the number of people who inject drugs undergoing confirmatory testing for HIV reached a total of 34 within three months after

the introduction of the project. While in 08/2018, 7% of people who inject drugs positively diagnosed by rapid testing actually underwent a confirmatory HIV test, this percentage increased to 32 % in 10/2018.

The upward trend sustained in 2019 but was impacted by the COVID-19 pandemic in 2020 (see Table A.3.2, indicated in bold letters). In 2019, the number of people who inject drugs tested at four harm reduction points of BPA 'Positive Movement' in Minsk was 4 155, and the level of HIV detection was 6.6%. No indicators were set for hepatitis C.

Table A.3.1. Indicators and results from 1 Aug to 31 Oct 2018

Indicator	08/2018	09/2018	10/2018
Number of people who inject drugs who underwent HIV rapid testing at a harm reduction point	485	449	512
Number of people who inject drugs with a positive HIV rapid test at a harm reduction point	89	54	71
Number of blood samples sent to lab for confirmatory HIV testing	7	4	23

Table A.3.2. Indicators and results at the harm reduction points from 1 Jan 2019 to 30 Sept 2020

Indicator	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020
Number of people who inject drugs underwent confirmatory HIV testing	30	29	20	10	19	6	11
Number of people who inject drugs who underwent blood test for CD4/VL	0	25	60	49	28	38	100
Number of people who inject drugs who visited an infectious disease specialist	2	5	33	10	5	0	22

Generally, the results were positively influenced by the availability of a nurse and the option of taking a blood sample immediately, but the COVID-19 pandemic negatively impacted the results.

The project made evident that timing is a crucial aspect when it comes to the success of the intervention: nurses have an important role in covering the client's needs and therefore need to be present at the checkpoints during the entire period of its operation. The work of a nurse covered 54% of the working time of harm reduction points while the work of infectious disease doctors covered around 13%. Laboratories must also be ready to take blood samples throughout the day (this option is currently limited until 1 pm).

Results confirm that people who inject drugs take the opportunity for low-threshold confirmatory HIV diagnosis and laboratory monitoring of the health status at the checkpoints. It is planned to advocate for expanding services with the following: dispensing pills at the checkpoint and including an infectious disease doctor to provide free-of-charge treatment for hepatitis C.

Routine reports/documentation and an assessment of quarterly performance indicators are performed as internal evaluation. External evaluation is taken care of by the donor of the project, the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Transferability and sustainability of the intervention

The intervention is considered adoptable and transferable to settings and countries by the submitter, and particularly relevant for countries with a complex system of diagnosing HIV infection and a high threshold for access to treatment. The low-threshold approach might also be important in countries where NGOs are not equal partners in the provision of services for the prevention and treatment of HIV infection/hepatitis C or where regulatory mechanisms inhibit the work of NGOs as service providers. The pilot project showed that joint work of a community organisation and doctors is a promising intervention to support linkage to treatment of HIV and HCV for people who inject drugs. Following the WHO recommendations for the diagnosis of HIV infection, testing with rapid tests at low-threshold points should be sufficient to receive treatment based on VL analysis.

The intervention has been funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria. In order to ensure sustainable operation with funding from the state budget, changes to the regulatory framework would be necessary.

The pilot project is linked to the following policy documents:

- Subprogramme 5 'Prevention of HIV infection' of the State programme 'People's health and demographic security of the Republic of Belarus' for 2016 – 2020; in January 2021 a National Programme for the next period (2021 – 2025) has been approved;
- Appendix 5 to the Decree of the Council of Ministers of the Republic of Belarus dated March 14, 2016 No. 200, which indicates that regional state programs aim to expand testing coverage;

- The readiness for dialogue and joint actions of national health authorities with patient organisations is declared in the Concept of Sustainable Development (2017) and in the 2nd Minsk Statement of the Ministers of Health of the EECA countries (2018);
- Action Plan to prevent the spread of HIV infection in Minsk, which has been developed to achieve the strategic goal of Joint UN Programme on HIV/AIDS (UNAIDS) '90-90-90', as well as the Minsk Statement in 2016 and the Second Minsk Statement in 2018, which is also a commitment to achieving the UNAIDS strategy.

The main success factors of BPA 'Positive Movement' intervention were considered to be:

- collaboration between low-threshold services and health-care settings through approaches focused on delivering services to key populations outside medical institutions;
- receive the maximum number of services in one place ('one stop shop');
- low-threshold approach: the right to services for all; easy access to prevention, care and support services; confidentiality; focus on the needs and life situation of the clients; and provision of services that reach the most marginalised groups of the population, in particular people who inject drugs.

Participation and inter-sectoral collaboration

Relevant partners in the development of the initiative have been the Ministry of Health, community of clients and members of BPA 'Positive Movement', as well as the Global Fund to Fight AIDS, Tuberculosis and Malaria within the framework of the project 'Strengthening of HIV and TB national systems of prevention, treatment, care and support in the Republic of Belarus'.

Relevant partners in delivery of the activities are healthcare providers ('City Clinical Infectious Diseases Hospital' in Minsk), nurses, infectious disease doctors (general practitioners) and the State institution 'Republican Centre for Hygiene, Epidemiology and Public Health'.

A.4 Hepatitis C bus (HCV-Bus)

Author	Martin Blindheim
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Country	Norway
Infections addressed	HCV, HIV/AIDS

General information on the overall project/programme

The regional pilot project HCV-bus started in August 2018 with a guaranteed funding until the end of 2022. It is implemented in Southern Norway, in the counties Innlandet, Viken, Agder, Rogaland and Vestland, where a majority of the population of Norway lives. The HCV-bus is a low-threshold initiative for current and former people who inject drugs, in particular people in OST. Initially, several prisons have been visited, but since 2020 most prisons offer HCV testing.

Background/rationale

The 2018 national strategy against hepatitis in Norway aims to reduce the number of new hepatitis C cases by 90% and to eliminate HCV as a public health problem by 2023. The vast majority of cases of hepatitis C in Norway are reported to be among current and former people who inject drugs. In order to reach the reduction goal, direct-acting antiviral therapy (DAA) was made available free of charge in 2018 to treat all people in Norway infected with hepatitis C. Every person who injects drugs with chronic HCV being tested and treated is seen as a step towards elimination. People who inject drugs who are tested and found without chronic infection have better reasons to remain uninfected.

The HCV-bus, initiated in 2018 by the user organisation proLAR Nett, is a joint effort including local municipalities and Norway's National Directorate of Health.

Goal and description of the intervention

The HCV-bus aims at recruiting current and former people who inject drugs in the municipalities in Southern Norway for testing, increasing HCV-activities in the municipality, and developing local HCV elimination plans. It supports the effort toward the elimination goal by bringing specialised healthcare to patients who rarely seek it out on their own, ensuring that it will be easier for current and former people who inject drugs to be tested and start treatment.

The HCV-bus is a mobile HCV-clinic in a van with equipment for testing for HCV-antibody and HCV-RNA and for measuring Fibrosis stage (Fibroscan®). There is also a possibility of HIV antibody testing in the bus. The staff consists of an auxiliary nurse and a driver/former drug user. The users in need of treatment are ideally followed up by the municipality and the specialised healthcare services.

The HCV-bus visits municipalities in Southern Norway with 10 000 inhabitants and up, with a known population of people who inject drugs and with some degree of low-threshold, drug-related health facilities. The bus stops 1-2 days in each municipality.

Results and evidence of impact

Around 50 municipalities have been visited since November 2019. Due to the COVID-19 pandemic, there has been a 10-week break in operation from mid-March to June 2020. Routine monitoring is conducted after every visit and compiled in an annual report. Number of tests performed as well as number of positive test results are indicated in Table A.4. Whether the visit actually increases HIV-activities in the municipality will become apparent when revisiting each municipality in 2021.

Table A.4. Indicators and results

11/2019–09/2020*	HCV RNA	HIV antibody
Number of tests	224	21
Number of positive test results	91	0

**with a break from March to June due to COVID-19*

Current experiences show that:

- a visit is generally welcomed and serves as a 'wake up call' at local level;
- the municipalities need time and support to organise a visit;
- the municipal chief doctor needs to be involved in organising a visit, especially in establishing cooperation with the specialised services; and
- people who inject drugs need to be well informed and mobilised prior to the bus visit.

Transferability and sustainability of the intervention

The submitter highlights that this intervention is transferrable to any country.

The work of the HCV-bus project is directly linked to the National strategy against hepatitis (2018) and the National Guidelines Hepatitis C (2019) and funded by the Directorate of Health as well as by pharmaceutical industry.

The main success factors of the HCV-bus intervention were considered to be:

- the national guidelines on hepatitis C that opened up treatment free of charge for all patients with hepatitis C;
- the start of this initiative in 2018 and the continuing effort and long-lasting engagement on HCV from the user organisation proLAR Nett;
- the funding in the initial phase from the pharmaceutical companies to set up the project;
- currently, the involvement from Directorate of Health and their funding since November 2019.

From a project's perspective, engaged people from the community and the user organisations, a clear project plan with cooperation partners and continuous funding needs to be ensured in order to sustain the intervention.

Participation and inter-sectoral collaboration

Relevant partners in the development of the initiative have been the National Directorate of Health, the National Institute of Public Health, regional hospitals, and pharmaceutical companies.

Relevant partners in delivery of the activities are:

- harm reduction service providers: anybody working with people who inject drugs in the municipalities;
- healthcare providers: anybody working with prevention of infectious diseases in the municipalities;
- local community: NGOs working with people who inject drugs in the communities;
- peers (other people who inject drugs): local organisations of people who inject drugs when such exist using snowballing methodology;
- non-governmental organisations: NGOs working with people who inject drugs in the communities.

Experience shows that the HCV-bus is welcomed, in particular in smaller municipalities, where specific action for the elimination of HCV is still lacking. So far, no municipality has rejected the opportunity to be visited, in

contrary, local NGOs welcome the bus. In particular, specialised healthcare units treating HCV have at times been rather reluctant to collaborate with the bus.

A.5 Community-based testing for people who inject drugs via a mobile outreach programme

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Country	Portugal
Infections addressed	HBV, HCV, HIV/AIDS, TB

General information on the overall project/programme

Ares do Pinhal is a drug treatment centre in Lisbon that provides low-threshold services, OST programmes, and mobile outreach programmes (MOP) to people who currently or formerly use drugs. The MOP includes three vans (two dedicated to OST and one with a focus on medical care and psychosocial support) that work directly in the community setting, with regular and permanent stops in the most strategic hotspots in Lisbon near at-risk communities. Generally, the main features of the MOP include improved access to healthcare, linkage to care with simplified admittance and social support, promotion of better living standards and general health, a low-threshold OST programme and an NSP programme, comprising additional safe use equipment. The MOP started an infectious diseases initiative in 2006 with a duration until December 2022, particularly addressing people in OST, migrants/asylum-seekers, people without housing and people who live with chronic infectious diseases. The initiative includes prevention, screening for infectious diseases, linkage to care, treatment and prevention of reinfection and relapse.

For further details on the MOP initiative to increase linkage to care see B.2 and to increase adherence to treatment see C.4.

Background/rationale

One of the targets of the MOP is the provision of measures that cover the health needs of people who use drugs/people who inject drugs, as well as a constant monitoring of potential health threats to its clients. In this context, infectious diseases are a concern because people who use drugs, in particular people who inject drugs, are at a higher risk of contracting HCV, TB, HBV, and HIV. Data from 2016 gathered by MOP indicate a much higher HCV prevalence among the users of the programme (67.6%) than in the general population. Infectious diseases among people who inject drugs have already been prevalent/detected in the 1990s among, at that time, a young user population (21.4% HBV prevalence; 83% HCV prevalence). Most of these clients are in their 50-ties nowadays and previous infections increased healthcare costs with hepatocellular carcinoma, one of the consequences of HCV infection, in Portugal. The introduction of direct-acting antivirals (DAAs) with a treatment efficacy of around 97% and an adequate safety profile with high tolerability resulted in better treatment adherence and clinical outcomes in these patients.

Goal and description of the intervention

The goal of the intervention is to increase effective HBV, HCV, HIV and TB screening and confirmatory diagnosis in people who inject drugs population groups.

In order to improve community-based testing for people who inject drugs, the MOP comprises regular screening for HCV and other infectious diseases (based on blood tests and radiography) at programme admission and on a regular basis. The low-threshold approach reduces the obstacles posed by the main healthcare access barriers and promotes a close relationship with the users. In addition, the participation of peer workers as well as other awareness and inclusion activities facilitates in accomplishing the goals of the program. The MOP is equipped with all relevant clinical and psychosocial support personnel (doctors, nurse, psychologists and social workers). Patient referral to other healthcare services that provide confirmatory diagnosis and treatment prescription is also within the scope of the project. Access to treatment is also provided at the MOP, based on a close partnership with local hospitals and other healthcare institutions (see B.2 and C.4).

Results and evidence of impact

From 1 January 2018 to 30 June 2020 a total 2 322 individuals were enrolled in the programme. Testing for HBV, HCV, HIV and TB was offered to all of them (see Table A.5). Indicators for linkage to care are provided in Table B.2. and indicators for adherence to treatment are showed in Table C.4.

Table A.5. Indicators and total number of people who inject drugs reached, 1 January 2018 to 30 June 2020

Indicator	HBV	HCV	HIV	TB
Number of people who inject drugs offered testing	2 322	2 322	2 322	2 322
Number of people who inject drugs tested	1 594	1 594	1 594	1 594
Number of people who inject drugs with a positive test result	59	964	245	20
Number of new cases diagnosed	2	96	2	20

The monitoring efforts include monthly reports for relevant stakeholders, a weekly meeting to assess the outcomes and evaluate needs of adjustments, and external process evaluation aiming to improve strategic long-term objectives.

Transferability and sustainability of the intervention

When transferring this intervention to other countries implementers should ensure that PWUD are seen as individuals/people, often with multiple immediate needs which should be responded to in parallel to responding to their health needs. Legal constraints may apply in other countries. Decriminalisation of drug use, a coordinated effort with relevant stakeholders, and the physical proximity to the community, provided by the mobile units, is paramount to the project's success.

The MOP is a regular programme of the drug service centre Ares do Pinhal and therefore an integrated part of the general budget of the facility based on regional and local funding, additional funding is provided by pharmaceutical industry.

The work of MOP is directly linked to the following policy strategies:

- WHO targets to eliminate HCV infection;
- Operational Plan for Integrated Responses (PORI) (Plano Operacional de Respostas Integradas – PORI), which is based on the principles of territoriality, integration, partnership and participation that constitute the strategic orientation framework defined by the ILO, in the context of the fight against poverty and social exclusion;
- National vaccination plan (Plano Nacional de Vacinação), with a special focus on TB, HBV and Influenza (in the case of homeless clients);
- National Programme for Viral Hepatitis (Programa Nacional para as Hepatites Virais), which is focused on addressing vaccination and treatment of viral hepatitis;
- National Programme for HIV and AIDS Infection (Programa Nacional para a Infeção VIH e Sida).
- National program for syringe exchange has provided much needed support for people who inject drugs though the exchange and distribution of syringes;
- As Lisbon region is one of the areas with highest burden of TB in Europe, MOP is also included in the network of the National Programme for Tuberculosis (Programa Nacional para a Tuberculose).

The main success factors of the MOP intervention were considered to be:

- the integrated approach, from screening to treatment follow-up, and the inclusion in the community setting;
- the over 30 years of experience in working with people who use drugs/people who inject drugs at Ares do Pinhal, which increases the capability of establishing meaningful and trusting relationships with people who use drugs;
- the focus on the users as patients, which provides a different perspective from what is commonly seen in other settings, with a strong focus on harm reduction and public health. The low-threshold OST is also a steppingstone in the development of such relationship that improves treatment adherence and compliance, as well as the NSP;
- the partnerships with peers and relevant stakeholders such as physicians, local hospitals, the pharmaceutical industry, and others (Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (SICAD), Lisbon City Council) which enhanced the MOP's own team's clinical and psychosocial support competencies.

Participation and inter-sectoral collaboration

Relevant partners in the development of the initiative have been SICAD and the Camara Municipal de Lisboa, both in the funding of the project and the monitoring of work. In addition, peers were actively involved in the development of the programme by sharing their personal experience with MOP's staff. Some peers are part of the MOP team and thus fulfilling a crucial role in the conceptualisation of activities that meet the needs of the target population.

Relevant partners in the delivery of activities are SICAD, the national HIV/AIDS programme, the national programme for HIV/AIDS, Hepatitis and Tuberculosis infection providing safe-use equipment and information material for the target group, Instituto Nacional de Emergência Médica (INEM) for support in medical emergency

situations, drug treatment service providers (withdrawal unit to promote access to more structured treatments and local drug service provider for further admission), as well as alcohol treatment units, specialised infection diseases centres providing screening for HIV, hepatitis, syphilis and TB. In addition, primary healthcare centres, hospitals and hospital pharmacies in case of hospitalisation, prisons to ensure OST during detention as well as street teams, therapeutic communities, shelter/housing centres, social services are interconnected with MOP. Community groups are implemented in local councils in order to promote the work within the community, to identify at-risk people who inject drugs, and facilitate the access to community resources. Peers facilitate the interaction with current people who inject drugs, by integrating the activities and promoting a trusting environment.

The development of partnerships with the entities proved to be different from what was anticipated. Partnerships have been clearly extended, allowing for a deepening of technical relations and collaboration in actions. It was also possible to involve new community partners, who revealed the need for cooperation with the project in order to solve problems related to addictive behaviours and their consequences in the community.

A.6 Find & Treat: peer-led blood-borne virus community outreach project

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Affiliation(s)	Find &Treat, UCLH NHS Trust/Institute of Global Health, UCL
Countries	United Kingdom
Infection(s) addressed	HBV, HCV, HIV/AIDS, TB

General information on the overall project/programme

The Find & Treat team provides low-threshold point of care testing and peer-led linkage to care services for infectious diseases to homeless, marginalised populations across London. Social circumstances of this population make it difficult to access services. The Find & Treat team carries out over 350 testing sessions per year in various outreach settings such as hostels for people without housing, day centres, drug treatment services or any congregate setting. The project started in June 2016 and funding is approved until April 2021, currently the commissioning decision for further funding is awaited in the beginning of 2021. The hepatitis C initiative is linked to the EU-funded HepCare EUROPE project.

Background/rationale

Work carried out by the team has shown that there is a strong co-linearity between blood-borne virus (BBVs) and TB infection among people without housing, driven by opiate and cocaine use. Up to 17% are infected with TB and 10% with chronic HCV infection, with up to 29% of HCV infected individuals infected with Latent Tuberculosis Infection [9]. Alongside this, homelessness has doubled in the capital in the past 10 years. Homeless people suffer from a huge inequality in terms of access to and provision of healthcare and have a prevalence of amenable health conditions far higher than the most deprived housed populations. This demonstrates the need for innovative outreach approaches that can deliver quality healthcare to marginalised populations.

Goal and description of the intervention

The Find & Treat Mobile Health Unit, UCLH NHS Trust, provides health screening for people without housing across London using community interventions and specialist outreach workers. Initially providing mobile chest x-ray technology to actively case find those with active tuberculosis, the service has, over the years, expanded to provide blood-borne viruses (BBV) testing and more recently COVID-19-tests in marginalised populations.

A peer-led community outreach service was developed to test individuals at risk of HCV, link them to specialist care and provide treatment support. Peer support workers (PSWs), who received basic training are provided by the homeless peer advocacy organisations Groundswell and the patient advocacy organisation the Hepatitis C Trust. PSWs are given additional training in BBV awareness, POC tests and the use of a Fibroscan® for liver fibrosis by the outreach team. They work alongside the **clinical team** that comprises of nurses, medical staff and a social worker.

People identified as having chronic hepatitis C infection are either offered same day (initiation of) treatment if they are non-cirrhotic and have no significant medical history. This involves a 'virtual' multi-disciplinary team approval process that comprises of two hepatologists and a pharmacist who checks eligibility for treatment initiation. If eligible, then pan-genotypic medication is taken to the individual in the community by a member of the hospital team and then followed-up in the community by the PSW and re-supplied with medication throughout treatment. End of treatment blood taking can also be carried out by the PSW, meaning that the patient may never have to attend any hospital appointments to achieve cure.

Those not eligible for same day treatment are supported by the PSWs with accompanied appointments for linkage to care and are referred directly to specialist treatment services where clinical appointments are made. PSWs would accompany individuals to hepatology and related healthcare appointments and cover associated travel costs. Other facilitators provided would be drinks and food while waiting as well as providing mobile phone top up credit. To support individuals through treatment, PSWs would keep in contact by regular phone calls or face-to-face meetings or supervising medication intake by directly observing therapy (DOT). This model of care is now being expanded to our hepatitis B and HIV outreach testing activities.

Other linkage to care and treatment support interventions involve Video Supported Care. Patients who require treatment support will receive a smart phone with a secure app that is used to monitor treatment adherence and other healthcare support interventions. Individuals provide a daily video clip that is viewed by a PSW or member of the clinical team. Other health related issues can be addressed in the same way. If videos are not being uploaded, then the individual is followed-up in the community by the PSW to address any health or social concerns that are preventing treatment adherence.

Results and evidence of impact

The first phase of testing before COVID-19 involved targeted testing of HCV based on risk factors, from September 2016 until March 2020. The second phase involved testing in temporary COVID-19 emergency accommodations that had a high number of individuals who recently became homeless. Follow-up data are currently pending. Table A.7.1 indicates the number of individuals reached.

The first phase of project showed a high detection rate as it was a targeted intervention aimed at those of high risk of HCV infection, therefore cannot be taken as a prevalence estimate of this population. However, it showed that a high number of individuals could be found with highly trained PSWs testing in the community. The second phase involved testing during the initial outbreak of COVID-19 in emergency accommodation that had a different demographic in terms of BBV risk. Further analysis is being done to describe this population and data will be published in due course.

Table A.7.1. Targeted HCV testing, before and during COVID-19 pandemic

	September 2016 - March 2020	During the COVID-19 pandemic
No. of individuals tested	792	1 031
No. of individuals tested HCV Ab positive	394 (49.7%)	110 (10.7%)
No. of individuals tested HCV RNA positive	310	45 (4.3%)
No. of individuals receiving peer support	310	45
No. of individuals engaged in treatment services	239 (77.1%)	45

A cost-effectiveness analysis evaluation has been conducted by the University of Bristol [10], and an observational study by a group led by University College London aimed to assess HCV burden in the project's target population and describe the role of peer support in the hepatitis C care pathway [11]. The economies of scale and the efficiency of multiple interventions carried out at the same time by the initial HCV outreach project are not only likely cost-effective/saving but are also well received by individuals.

HBV testing started in the most recent phase of the work during the COVID-19 pandemic in the spring of 2020. To date, Find & Treat has provided 600 tests, with seven (1.2%) individuals testing positive for HBV.

The opportunity to start HIV testing has shown a surprisingly high prevalence of HIV and a high proportion of individuals who either did not know their status (23.1%) or were positive and not on treatment (25%; see Table A.7.2). This has implications for further interventions in this population in terms of the UNAIDS 90-90-90 initiative.

Table A.7.2. Targeted HIV testing

	March 2020 - November 2020
No. of individuals tested	934
No. of individuals tested HIV positive	26 (2.8%)
No. of individuals aware of status, in treatment	15
No. of individuals aware of status, not in treatment	5
No. of individuals not aware of status	6
No. of individuals receiving peer support to link to care	26

Tuberculosis screening via Mobile Chest X-Ray is carried out on approximately 8 000 people per year with a detection rate of 250 per 100 000. The proportion of individuals with an abnormal chest X-ray and requiring an onward referral is approximately 12.5%.

Transferability and sustainability of the intervention

The intervention is very much transferrable, and lessons learned were shared with the collaborators of the HepCare EUROPE project in Ireland, Spain, and Romania.

The service was developed by funding from the European Commission through its EU Third Health Programme, and by University College London as well as University College London Hospitals NHS Trust. The data outputs attracted funding from NHS England as part of its HCV elimination strategy and more recently HIV tests provided by the Fast Track Cities Initiative.

The work of the Find & Treat Mobile Health Unit's HCV initiative is directly linked to the NHS England Hepatitis C Elimination Strategy.

The main success factors of the Find & Treat Mobile Health Unit were considered to be:

- The central role of peers to the project who have been involved with the co-design and the implementation throughout. With their lived experience of a lifestyle or condition, peer support workers (PSWs) can share similar experiences or characteristics with the target intervention group.
- The extensive training and clinical supervision provided to PSWs, experts by experience, to enable them to be highly effective healthcare workers.
- The flexibility and low-threshold for testing facilitates reaching individuals who it is often difficult to engage with services.
- Offering multiple interventions at the same time is efficient and well received by service users.

Quality data, founded on strong connections to a research team, have supplied the evidence that has sustained the service to date. Alongside quantitative and qualitative data, strong links to both peers and grass roots organisations are needed to ensure that interventions are designed to be relevant to the target population.

Participation and inter-sectoral collaboration

Relevant partners have been harm reduction providers and NGOs (homeless and drug services) in the development of screening interventions and peers in the development of the models. All participating cities are affiliated to universities.

Relevant partners in the delivery of activities are drug treatment service providers (Change Grow Live United Kingdom, Turning Point United Kingdom), healthcare providers (London Operational Delivery Network (ONDs), Royal Free Hospital NHS Trust, Imperial NHS Trust, St Georges NHS Trust, Barts Health NHS Trust, Kings NHS Trust), Institute of Global Health, University College London, Groundswell United Kingdom – homeless advocacy organisation and the Hepatitis C Trust – Patient advocacy organisation.

The collaborations with the organisations Groundswell and the Hepatitis C Trust have enabled to ensure that peers are integral part of the development and implementation of the service. By now, a third of the team comprising of people with lived experience of homelessness or substance use who are now in full-time salaried roles. This provides a possibility of career progression into health and social care.

This intervention would not have been successful without the input and buy in from personnel across disciplines and services. Effective collaboration between key organisations is crucial in attempting to roll out effective screening interventions in the community.

B. Interventions to increase linkage to care for people who inject drugs

Table 5. Overview on models of good practice to increase linkage to care for people who inject drugs

	Name of project	Affiliation	Country	Infection(s) addressed
B.1	Improving linkage to treatment of HIV infection for people who inject drugs in Minsk	Belarusian Public Association 'Positive Movement'	Belarus	HIV/AIDS
B.2	Mobile Outreach Programme	Associação Ares do Pinhal	Portugal	HBV, HCV, HIV/AIDS, TB
B.3	REACH-U – Point-of-care hepatitis C antibody and RNA testing and linkage to care to enhance uptake of treatment in outreach settings	CRESCER - Associação de Intervenção Comunitária	Portugal	HCV
B.4	Hepatitis C Elimination Programme	NHS England and NHS Improvement	England	HCV
B.5	Engaging the disengaged: ITTREAT, VALID and END-C Studies	Brighton and Sussex Medical School and Brighton and Sussex University Hospital, Brighton	United Kingdom	HCV

B.1 Improving linkage to treatment of HIV infection for people who inject drugs in Minsk

Author Tatsiana Piachko
Affiliation Belarus Public Association 'Positive Movement'
Country Belarus
Infections addressed HIV

General information on the overall project/programme

A local pilot project in Belarus that started in 2018 initiated additional interventions aiming to further improve linkage to treatment of HIV infections for current people who inject drugs in August 2020 by specifically addressing key populations like MSM, adolescents, partner contacts, sex workers, and pregnant women. The initiative developed by the Belarus Public Association 'Positive Movement' - implemented at three low-threshold (mobile and fixed) sites in Minsk, and at two outpatient centres - is funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Outreach workers systematically try to attract clients to the harm reduction sites, where – apart from NSP and other services – HIV and hepatitis C testing is provided free of charge. The initiative has been highly affected by the COVID-19 initiative and efforts were made to tackle challenges caused by containment measures.

For more details on the BPA 'Positive Movement' initiative to enhance community-based testing, see A.3.

Background/rationale

Prior to the implementation of the pilot project, the provision of NGO-based services related to diagnosis and treatment of HIV infections for people who inject drugs was considered inconceivable due to the specific conditions for community-based organisations in Belarus. Since 2014, the NGO 'Positive Movement' advocated for access to HIV diagnostics and treatment services 'at one point', not only in healthcare facilities, but also at harm reduction points. Years of advocacy efforts and work experience have led to the approval and support of partners in the implementation of the intervention.

In order to increase the HIV treatment (ART) rate among people who inject drugs as well as to fulfil regional and global health targets, the involved harm reduction sites systematically started reducing barriers to ART for their client. Specific services have been established in harm reduction points to provide a 'one-stop-shop' for testing, blood sampling for confirmatory HIV testing, as well as blood sampling to assess the clinical state (CD4, VL) and treatment in order to avoid the need to visit different institutions. The programme includes newly diagnosed clients as well as clients with a discontinuation of former treatment.

Goal and description of the intervention

The overall goal is to increase the ART uptake rate among people who inject drugs.

In order to increase linkage to HIV care, the harm reduction sites of BPA 'Positive Movement' started to offer incentives in form of vouchers for a supermarket to its clients aiming to better involve them in the HIV treatment cascade. In addition, social and outreach workers were encouraged to actively accompany clients in the HIV treatment cascade.

An outreach approach, jointly conducted by a peer consultant and a medical doctor is used to regularly trace and contact HIV-positive people who inject drugs, who are currently not in treatment. The delivery of ART to those people who inject drugs with a positive HIV-status is conducted by BPA 'Positive Movement' from the Minsk City Clinical Infectious Disease Hospital.

The COVID-19 pandemic containment measures in Belarus highly affected the planned interventions. Active tracing of HIV-positive clients not in treatment has only been feasible via telephone. Additionally, the involved hospital has been set under quarantine and therefore the collection of tests for CD4 cells and viral load, as well as planned hospitalisations temporarily had to be suspended. The programme also had to deal with a shortage of available tests for CD4 and viral load in January 2020 as well as the blood sampling from people who inject drugs at harm reduction sites was stopped, because laboratories were overloaded due to COVID-19 tests.

To tackle all these COVID-19 related challenges, social workers organised the blood sampling as well as the delivery of ART to people at home. In June 2020, BPA 'Positive Movement' reached an agreement with the Republican Centre for Hygiene, Epidemiology and Public Health to organise the testing for VL and CD4 of the blood samples, collected from clients at the harm reduction sites. The volume of tests/investigations can be up to 20 samples per week. Blood sampling at the prevention sites for people who inject drugs in Minsk has been carried out; those clients who have not conducted testing in 2020 are considered the primary target group.

Results and evidence of impact

Table B.1 indicates the impact of the implementation of the 'pay the patient for treatment' strategy in August 2020. Linkage-to-care-indicators like registration with an epidemiologist, undergoing CD4/VL surveillance as well as a visit to a specialist show an increase.

Table B.1. Indicators and results of intervention incentive distribution

Indicator	Q1/2020	Q2/2020	Q3/2020
Number of people who inject drugs who have been diagnosed with HIV by rapid testing at harm reduction sites	59	37	47
Number of people who inject drugs who underwent confirmatory HIV testing	19	6	11
Number of people who inject drugs registered with an epidemiologist	2	0	9
Number of people who inject drugs who underwent blood sampling to assess clinical state (CD4/VL)	28	38	100
Number of people who inject drugs who visited an infectious disease specialist	5	0	22

In Q2/2020, the results were significantly influenced by the COVID-19 pandemic, particularly due to changes in the operating mode of healthcare institutions (temporary refusal to admit patients, accepting blood tests). Routine reports/documentation is performed, and an internal and external evaluation is planned in the future.

Transferability and sustainability of the intervention

The intervention is considered adoptable and transferable to settings and countries by the submitter. Enabling factors listed refer to the principles of work of NGO-based harm reduction sites, reliance on the community and peer-to-peer assistance, to the ability to implement a new approach based on incentives within the framework of international technical assistance projects (innovations outside the framework of regulatory documents and regulations) and long-term advocacy about funding.

The project is linked to Subprogramme 5 'Prevention of HIV infection' of the State programme 'People's health and demographic security of the Republic of Belarus' for 2016 – 2020. In January 2021 a National Programme for the next period (2021 – 2025) has been approved.

In addition, it is also interlinked to the Action Plan to prevent the spread of HIV infection in Minsk, which has been developed to achieve the strategic goal of Joint UN Programme on HIV/AIDS (UNAIDS) '90-90-90'.

The main success factors of BPA 'Positive Movement' intervention were considered to be:

- The combination of harm reduction approach adapted to client's needs;
- A strategy of creating motivation using external stimulation to start and undergo ART. After establishing contact with a client, social workers worked on the transition of external motivation to internal (the need to be treated and visit the point).

Further information on the initiative can be found here.

Participation and inter-sectoral collaboration

Apart from harm reduction service providers (BPA 'Positive Movement'), healthcare providers (Institution 'City Clinical Infectious Diseases Hospital' in Minsk), the local PLHIV community and outreach workers from the peer community are involved in the delivery of the intervention.

Equal cooperation between NGOs and healthcare institutions that diagnose and treat HIV infection increased the effectiveness of efforts to involve PLHIV in treatment. The most reluctant patients are unmotivated clients and solely counting on voluntary participation/individual motivation reduces the compliance for treatment. To address this, BPA 'Positive Movement' make use of peer counselling and socio-psychological strategies, such as 'pay the patient for treatment'.

B.2 Linkage to care for people who inject drugs via a mobile outreach programme

Author	Elsa Belo
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Country	Portugal
Infections addressed	HBV, HCV, HIV, TB

General information on the overall project/programme

Ares do Pinhal is a Lisbon based drug treatment centre, which provides low-threshold services, OST programmes and mobile outreach programmes (MOP) to people who currently and formally use drugs. The MOP includes three vans (two dedicated to OST and one with a focus on medical care and psychosocial support) that work directly in the community setting, with regular and permanent stops in the most strategic hotspots in Lisbon near at-risk communities. Generally, the main features of the MOP include improved access to healthcare, linkage to care with simplified admittance and social support, promotion of better living standards and general health, a low-threshold OST programme and an NSP programme, comprising additional safe use equipment. The MOP started an infectious diseases initiative in 2006 with a duration until December 2022, particularly addressing people in OST, migrants/asylum-seekers, people without housing and people who live with chronic infectious diseases. The initiative includes prevention, screening for infectious diseases, linkage to care, treatment and prevention of reinfection and relapse.

Details on the MOP initiative to enhance community-based testing are provided in A.5 and to increase adherence to treatment in C.4.

Background/rationale

One of the targets of the MOP is the provision of measures that cover health needs of people who use drugs/people who inject drugs as well as a constant monitoring of potential health threats of its clients. In this context, infectious diseases are a concern as people who use drugs in particular people who inject drugs, are at a higher risk of contracting HCV, TB, HBV and HIV. Data from 2016 gathered by MOP indicates a much higher HCV prevalence among the users in the programme (67.6%) than in the general population. Infectious diseases among people who inject drugs have already been prevalent/ detected in the 1990s among, at that time, a young user population (21.4% HBV prevalence; 83% HCV prevalence). Most of these clients are in their 50-ties nowadays and previous infections increased healthcare costs with hepatocellular carcinoma, one of the consequences of HCV infection, in Portugal. The introduction of direct-acting antivirals (DAAs) with a treatment efficacy around 97% and an adequate safety profile with high tolerability allowed for better treatment adherence and clinical outcomes in these patients.

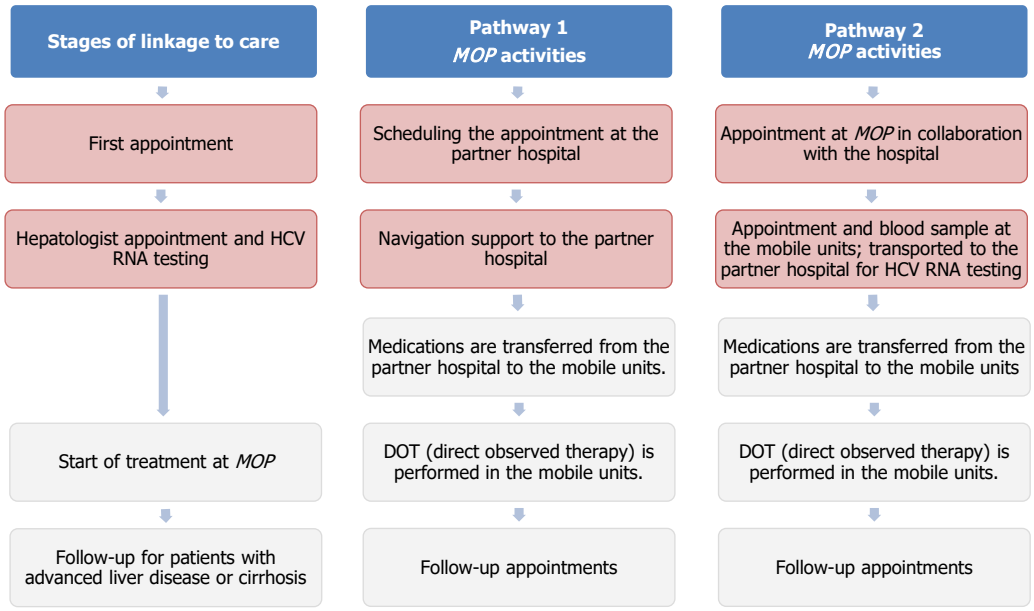
Goal and description of the intervention

Goal of the intervention is to increase linkage to care for infectious diseases among people who inject drugs by providing an integrated approach facilitating confirmatory diagnosis and treatment initiation.

In order to increase linkage to care for people who inject drugs, patient referral to other healthcare services that provide confirmatory diagnosis and treatment prescription is the scope of the project. Based on a close partnership with local hospitals and other healthcare institutions access to treatment is facilitated. Apart from this, the MOP is equipped with all relevant clinical and psychosocial support personnel (doctors, nurses, psychologists and social workers). The low-threshold approach reduces the obstacles to access healthcare and promotes a close relationship with users. In addition, the participation of peer workers and other awareness and inclusion activities facilitate in accomplishing the goals of the program.

MOP follows a comprehensive and collaborative approach, which distinguishes between two pathways for HCV treatment. People who inject drugs are either supported to schedule and attend the appointments at partner hospitals (Pathway 1) or appointments (incl. blood samples) take place at MOP and blood samples are transported to partner hospitals (Pathway 2). In any case, medications are transferred from partner hospitals to mobile units to provide DOT. Crucial steps concerning linkage to care are highlighted in red (see Figure B.2).

Figure B.2. Distinct pathways to increase linkage to care for HCV treatment through the Mobile Outreach Programme



Results and evidence of impact

The integrated approach provided by MOP seems to ease the access to care and therefore has a positive impact on linkage to care for people who inject drugs (see Table B.2). The number of people who inject drugs tested are provided in Table A.5 and referring indicators for linkage to care in Table B.2.

Table B.2. Indicators for linkage to care and total number of people who inject drugs reached through MOP

Indicator	HBV	HCV	HIV/AIDS	TB
Number of people who inject drugs tested	1 594	1 594	1 594	1 594
Number of people who inject drugs with a positive test result	59	964	245	20
Number of people who inject drugs with a recorded appointment	5	354	220	20
Number of people who inject drugs who started treatment	1	153	43	20

It must be considered that this at-risk population is often limited in their ability to resort to healthcare services. The sound relationship developed with the patients streamlines their ability to follow the recommendations and pursue adequate treatment protocols and medical assistance. Psychosocial support is an important feature, since social workers and psychologists are always available to create a positive and supportive environment to people who inject drugs in the programme. The implemented pathways increase trust since most of the process is directly accompanied by MOP's staff, namely nurses and physicians that work daily with the users. In this regard, linkage to care is an essential feature of our MOP and a significant contribution to the overall programme goals.

Monitoring consists of monthly reports for relevant stakeholders, a weekly meeting to assess the outcomes and evaluate needs of adjustments and external process evaluation aiming to improve strategic long-term objectives.

Transferability and sustainability of the intervention

When transferring this intervention to other countries it must be ensured that the PWUD are regarded as patients. Legal constraints may apply in other countries. Decriminalisation of drug use, a coordinated effort with relevant stakeholders, and the physical proximity to the community, provided by the mobile units, is paramount to the project's success.

The MOP is a regular programme of the drug service centre Ares do Pinhal and therefore an integrated part of the general budget of the facility based on regional and local funding, additional funding is provided by pharmaceutical industry.

The work of MOP is directly linked to the following policy strategies:

- WHO targets to eliminate HCV infection.
- Operational Plan for Integrated Responses (PORI) (Plano Operacional de Respostas Integradas – PORI), which is based on the principles of territoriality, integration, partnership and participation that constitute the strategic orientation framework defined by the ILO, in the context of the fight against poverty and social exclusion.
- National vaccination plan (Plano Nacional de Vacinação), with a special focus on TB, HBV and Influenza (in the case of clients without housing).
- National Programme for Viral Hepatitis (Programa Nacional para as Hepatites Virais), which is focused on addressing vaccination and treatment of viral hepatitis.
- National Programme for HIV and AIDS Infection (Programa Nacional para a Infeção VIH e Sida).
- National program for syringe exchange has provided much needed support for people who inject drugs though the exchange and distribution of syringes.
- As Lisbon region is one of the areas with highest burden of TB in Europe, MOP is also included in the network of the National Programme for Tuberculosis (Programa Nacional para a Tuberculose).

The main success factors of the MOP intervention are considered to be:

- The integrated approach, from screening to treatment follow-up, and the inclusion in the community setting.
- The experience of over 30 years in working with people who use drugs/people who inject drugs at *Ares do Pinhal* that increases the capability of establishing meaningful and trusting relationships with people who use drugs. Considering the drug users as patients provides a different perspective from what is commonly seen in other settings, with a strong focus on harm reduction and public health. The low-threshold OST is also a steppingstone in the development of such relationship that improves treatment adherence and compliance, as well as the NSP.
- The MOP's team seasoned competences for clinical and psychosocial support and, the partnership with peers and relevant stakeholders such as physicians, local hospitals, pharmaceutical industry and others (SICAD, Lisbon City Council).

Participation and inter-sectoral collaboration

Relevant partners in the development of the initiative have been SICAD and the Camara Municipal de Lisboa, both in the funding of the project and monitoring of work. In addition, peers were actively involved in the development of the programme by sharing their personal experience with MOP's staff. Some peers are part of the MOP team and thus fulfilling a crucial role in the conceptualisation of activities that meet the needs of the target population.

Relevant partners in the delivery of activities are SICAD national HIV/AIDS programme, national Programme for HIV/AIDS, Hepatitis and Tuberculosis infection providing safe use equipment and information material for the target group, Instituto Nacional de Emergência Médica (INEM) for support in medical emergency situations, drug treatment service providers (withdrawal unit to promote access to more structured treatments and local drug service provider for further admission) as well as alcohol treatment units, specialised infection diseases centres providing screening for HIV, Hepatitis, Syphilis as well as TB. In addition, primary healthcare centres, hospitals and hospital pharmacies in case of hospitalisation, prisons to ensure OST during detention as well as street teams, therapeutic communities, shelter/ housing centres, social services are interconnected with MOP. Community groups are implemented in local councils in order to promote the work within the community, to identify at-risk people who inject drugs and facilitate the access to community resources. Peers facilitate the interaction with current people who inject drugs, by integrating the activities and promoting a trusting environment.

Partnerships have been clearly extended allowing for a deepening of technical relations and collaboration in actions. It was also possible to involve new community partners, who proved effective to solve problems related to addictive behaviours and their consequences in the community.

B.3 REACH-U – Point-of-care hepatitis C antibody and RNA testing and linkage to care to enhance uptake of treatment in outreach settings

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Country Portugal
Infections addressed HCV

General information on the overall project/programme

CRESCER is a local low-threshold service, providing outreach services for approximately 2 000 PWUD per year, including 500 with recent injecting drug use, operating daily in the urban areas of Lisbon with high levels of drug consumption.

Barriers for attending specialist-based appointments in hospitals has led to suboptimal RNA testing and uptake of HCV therapy. In order to increase involvement in HCV care cascade, CRESCER initiated the pilot project 'REACH-U' in August 2020, which is implemented in low-threshold setting, outreach programmes (shelters) addressing current and former people who inject drugs with a specific focus on people in OST, migrants/asylum-seekers, MSM and youth who inject drugs (15-24 years). The project will continue until December 2022.

Details on the 'REACH-U' initiative to enhance community-based testing are provided in A.5 and to increase adherence to treatment in C.3.

Background/rationale

In Portugal, in 2019, approximately 25 000 people were living with chronic HCV infection. Most cases of HCV infection occur among people who inject drugs [6,7]. Among current people who inject drugs, the proportion of people living with HCV infection is estimated to be 66%. Among people in outreach, the prevalence varies between 18% (new participants), 37% (readmitted participants) and 79%–82% (people who have a history of injecting drug use) [8].

Since October 2018, CRESCER has been running a point-of-care (POC) HCV antibody testing intervention combined with nursing and peer-based outreach to enhance HCV testing and treatment among vulnerable groups. The intervention is aiming to meet socially isolated people who inject drugs in their own environment (e.g. areas with high levels of drug consumption), who refuse to leave the neighbourhoods and do not access other health services, including low-threshold or outreach services, e.g. opioid substitution treatment, mobile testing units or shelters. Between October 2018 and July 2020, 142 participants were enrolled. Overall, 37% (52 of 142) were HCV antibody positive and referred for specialist assessment. Only 37% (19 of 52) attended a specialist appointment. Among the 10 people with detectable HCV RNA, 40% (n=4) initiated treatment.

In August 2020, CRESCER implemented the pilot project REACH-U to enhance HCV testing and treatment uptakes and began to include HCV RNA testing on the field.

Goal and description of the intervention

The goal was to decrease the barriers for attending specialist-based appointments in hospitals and increase the HCV treatment uptake of PWUD and other vulnerable population groups, such as people without housing, asylum-seekers and migrants, with whom CRESCER works in related projects. In the future, this initiative is intended to integrate other low-threshold and outreach services, like shelters.

To increase linkage to HCV care, point-of-care HCV antibody and RNA testing and linkage to care through nurse-services and peer-based outreach has been implemented. Participants with detectable HCV RNA following finger-stick HCV RNA testing, have an HCV clinical assessment run by an experienced nurse at the CRESCER site, including standard phlebotomy (genotype, ALT, AST, platelets) and Fibroscan® (not mandatory but occurs when possible).

An HCV virtual appointment is booked at the CRESCER site or in another place in the community (e.g. drop-in centre, shelter), depending which place meets best the person's needs. The appointment is performed by a specialist experienced in prescribing DAA therapy. If the participant is HCV RNA positive, HCV therapy is prescribed at this appointment. Participants receive an incentive of 10 Euro for this visit. CRESCER team also guarantees transportation or helps with transport tickets in case of need. In this model, all medical procedures are provided in the community setting and the person does not need to go to the hospital. A peer navigator assists in promoting linkage to care and foster patient's trust in healthcare. The specialised outreach team consists of two harm reduction service professionals, a nurse and a peer.

Results and evidence of impact

The proportion of participants who engage in virtual specialised appointments was defined as an impact indicator for linkage to care.

At the beginning and at the end of each individual participation in the project a participant-administered survey is conducted. A non-randomised trial is planned to evaluate this intervention. In addition, an activity report to the funding bodies will be produced.

No metrics have been reported due to the recent implementation of the pilot project REACH-U in August 2020. Although effectiveness could not be documented at the time of submission, the general consensus of the Expert Panel was to include the pilot project as a relevant model of intervention.

Transferability and sustainability of the intervention

The submitter considers the initiative as transferable to other national harm reduction and/or outreach services and prisons, if there is political will as well as appropriate flexibility of healthcare services. Existing harm reduction service approaches is a pre-condition of implementing it in other countries.

REACH-U is conceptualised as a pilot project and funded by specific national and regional funding as well as co-funded by a pharmaceutical company. The work of REACH-U is directly linked to the Portuguese national programme for viral hepatitis, 2017 report 'Programa nacional para as Hepatites Virais'.

In order to sustain the intervention, the submitter identifies a need in development of outreach work and guaranteed outreach workers specialised training. Flexible procedures based on harm reduction approach need to be implemented and a good collaboration with the healthcare system needs to be ensured to facilitate access to appointments and treatment for people who inject drugs. The implementation of peer navigators is also considered as crucial for the sustainability of the intervention.

Furthermore, REACH-U indicates the establishment of public and private collaborative partnerships, advocacy campaigns that involved inviting public and private institutions to the field and the constant search for public and private financial support as core for the success of the intervention.

Participation and inter-sectoral collaboration

Peer workers have been relevant partners in the development of the overall initiative, by ensuring that the needs of the target population were met. CRESCER's multi-disciplinary team with long-time outreach working experience helped to identify barriers to community-based testing and to develop strategies and interventions to overcome challenges. Gastroenterology experts have provided clinical and research advice and a pharmaceutical company clinical advice.

Holding a key role in the delivery of overall REACH-U activities are peer navigators to enhance participation in HCV screening and facilitate linkage to care and treatment, a specialised outreach team with two harm reduction service providers, namely a nurse and a peer, as well as a medical doctor specialised in prescribing DAA therapy from Gastroenterology Service – Santa Maria Hospital (Lisbon).

B.4 Hepatitis C elimination programme: Operational Delivery Networks with peer involvement

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Infection addressed	HCV

General information on the overall project/programme

The Hepatitis C Elimination Programme is a national programme implemented by NHS England/NHS Improvement, which started in 2017 and will be ongoing until August 2025. It is addressing the general population with a remit to find and treat individuals living with hepatitis C. The target population therefore includes former and current people who inject drugs. The programme is established in various settings, including low-threshold settings, OST programmes, prison, outreach programmes and pharmacies. To increase linkage to care, the programme strongly emphasises the important role of peers in the delivery of all activities and services.

Background/rationale

Hepatitis C is thought to affect 89 000 people in England - the majority of those being from marginalised and underserved groups. It significantly affects those with a history of injecting drug use, many of whom (especially recent or current injectors) cycle through the prison system for regular acquisitive crime. The WHO has proposed

an elimination target for hepatitis C as a public health issue by 2030. NHS England has committed to achieve this by 2025 and is embarking on a significant expansion of curative treatment capacity utilising direct-acting antivirals (DAA).

The National Hepatitis C elimination strategy has established a system of care with co-ordinated access to HCV treatment managed by Operational Delivery Networks (ODNs) responsible for the governance of service delivery and with a remit to find and treat individuals living with hepatitis C. The HCV Strategic Procurement completed in May 2019 and contracts were awarded to three pharmaceutical suppliers. The objectives of the Strategic Procurement were to reduce the cost of treatments to enable population supply; enable Pharma funding of HCV related services and accelerate the date of elimination to 2025. Funding has additionally been provided to several Elimination Initiatives, including, but not limited to the integration of pre- and post- prison probation community, likely to have similar rates of positivity to those in prison, to the widening of the programme to presumed 'lower return' communities, to contact tracing/testing networks and to an improved understanding of the target population and the performance of ODNs in patient finding.

Goal and description of the intervention

The peer programmes are established in all of the 22 Operational Delivery Networks (ODNs). In order to increase linkage to care, each ODN has at least one peer from the Hepatitis C Trust, aiming to further support individuals who are having an HCV test or are being initiated onto treatment. Peers are involved in all settings the HCV Elimination Programme currently operates in, such as prisons, probation, community pharmacies, homeless shelters, outreach and community services, and drug and alcohol services. Peers are trained for their activities and are involved in additional work streams, including Hepatitis C Helpline or *Follow me*, a programme to support the most marginalised user groups with HCV and very limited or no contact with health services.
The objectives of peer involvement are:

- Awareness-raising activities: deliver workshops and staff training across ODNs, and build partnerships with organisations involved in the HCV Elimination Programme
- To test individuals: facilitating POC testing or supporting self-testing
- Supporting individuals to complete the HCV pathway**:** arrange meetings with patients to build relationships, link them to different services, transport individuals to their specialist appointments, support access to prescribed medication, and add a personal, lived experience perspective to the HCV elimination programmes.

Results and evidence of impact

The following impact indicators have been defined for the pilot project the:

- number of people who refused a test or treatment who changed their minds after speaking to a peer;
- number of drug service referrals;
- number of people who inject drugs starting treatment;
- number of people completed treatment; and
- number of SVR12 following treatment initiation.

To date, over 4 000 people have benefitted from a peer workshop, conducted by the Hepatitis C Trust, and over 100 people have started treatment with the help of peers.

Qualitative evidence is gained from ODNs/clinical staff/prison staff/substance misuse services showing that peers are intrinsic to ensuring as many individuals are tested as possible, and that they continue to engage throughout the care pathway.

For example, at Her Majesty's Prison (HMP) Drake Hall, peers visited those who had refused testing in their own residences and at the gymnasiums. Due to this, at the end of the first high intensity test and treat day, 95% of women had been tested. At the same time, prisons utilised the technology available to them to phone prisoners in their cells and provide confidential HCV support, negating the need for prisoners to visit healthcare while providing maximum 1:1 support. Thus, peers both increase the uptake in testing and provide additional support where needed.

At HMP New Hall, another women's prison, peers were able to talk to a mother and daughter who shared a cell. The former had tested RNA positive for HCV, but due to stigma did not want to seek treatment within the prison. Through discussing options with both mother and daughter present, and sharing her own personal experience with HCV treatment, both mother and daughter felt they understood HCV more, and an additional appointment was made to start treatment. Peers are therefore best placed to assist those who might be initially reluctant to engage through sharing their own experiences.

Transferability and sustainability of the intervention

Concerning transferability, the submitter highlights that the peer support approach is recommended by the WHO strategy on viral hepatitis. It has been used in numerous settings including mental health and HIV and could be used in other settings and countries. NHS England and NHS Improvement and pharmaceutical industry are funding the peer programmes. The initiative is directly linked to the WHO elimination targets for HCV infection by 2030 as well as the National Hepatitis C elimination strategy.

The main success factors for the peer support approach of the Hepatitis C Elimination Programme were considered to be:

- A close partnership between The Hepatitis C Trust (who provide the peers), NHS England and NHS Improvement as well as pharmaceutical industry (who fund the peers) and the ODN (who employ the peers). The Hepatitis C Trust also has excellent partnerships with drug and alcohol services, which is key to accessing current or former people who inject drugs.
- Presence of peers in all ODNs and in a variety of services. This ensures some continuity in the services offered as part of the HCV Elimination Programme and provides an opportunity to follow up with those who use several services but still are difficult to engage.
- Peers experienced and effective in finding those lost to services or those disillusioned by statutory services.
- Peers able to actively engage with healthcare – and other services, such as housing – services among marginalised groups, seeing the individual as a whole person rather than just their hepatitis C or people who inject drugs status.

From a project's perspective, the following needs to be done to sustain the intervention:

- Continued support from all collaborators – providing the peers access to prisons, for instance, which needs strong partnerships with the prison service.
- The work of the peers and the evidence behind using them need to be understood by all involved services.
- Retaining the passionate and experienced peer workers will be critical.
- Ensure data collection is done effectively.
- Continued feedback and impact questionnaires from service users.

Participation and inter-sectoral collaboration

The main collaborator is the Hepatitis C Trust, through which the peers are accessed. They are then employed through the regional ODN and work primarily in either the community or health and justice settings. Peers are involved in the development as well as the service delivery. Peers are defined as those with lived experience of hepatitis C. It is assumed that the majority of peers are former people who inject drugs. The peer work is also connected to a community pharmacy programme. Peers can work with any pharmacy that signs up to increase linkage to care with individuals testing for HCV.

Stakeholders involved in the elimination programme have been extremely impressed by the work of the Hepatitis C Trust and its peers, and the main lessons learnt are as follows:

- Peers are a fundamental part of the Hepatitis C Elimination Programme in England.
- Whether the peers are employed in the community or prisons or are funded through NHS England/Improvement or the pharmaceutical companies, the outcome is the same.
- Although all stakeholders are on board with the peer work, there has been difficulty in some of the prisons with the peers gaining access to establishments, as some are ex-offenders. Mitigation of this involves working closely with the prisons so they understand the role of the peers in the wider elimination programme. Organisationally, Her Majesty's Prison and Probation Service have been a supportive partner.

B.5 Engaging the disengaged: ITTREAT, VALID and END-C studies

Author	Sumita Verma
Affiliations	Brighton and Sussex Medical School and Brighton and Sussex University Hospital
Country	United Kingdom
Infection addressed	HCV

General information on the overall project/programme

'Engaging the disengaged' is a regional integrated HCV service for PWUDs at a large drug treatment centre in Brighton (South East England) and further extended to Eastbourne, Hastings, Worthing, Bognor Regis and Chichester (Sussex), focussing on current and former people who inject drugs and people without housing. The initiative is interlinked with the ITTREAT study (2013-2021) [12,13], with the VALID study (2015-2018) [14] and

the END-C study (2019-2022). Till date, about 1 000 vulnerable adults have been linked into care with about 350 receiving HCV treatment, SVR rates varying between 83%-90%, with high overall service uptake (>95%) and compliance (>93%).

Background/rationale

In May 2016, the United Kingdom signed the 2016 WHO Global Sector Strategy with the aim of eliminating hepatitis C Virus (HCV) by 2030. Alongside the introduction of direct-acting antiviral (DAA) therapy, National Health Service (NHS) England created 22 HCV Operational Delivery Networks (ODNs) to coordinate HCV care at a national level. Brighton and Sussex University NHS Hospital Trust (BSUHT) is the 'hub' of the Sussex ODN. In England, HCV prevalence is highest in under-served populations, PWUD and people without housing. In Brighton and Hove, between 03/2016 and 03/2017, 1: 300 of the population were cocaine/opiate users and in 2019, 1:150 of the population were without housing.

With the availability of DAA, a novel solution is to move HCV care from the traditional hospital to community-based sites such as drug treatment centres and hostels/shelters for homeless people. Experts from the Brighton and Sussex Medical School were among the first ODNs to develop 'one-stop' HCV community care models.

The ITTREAT study (2013-2021) set up an integrated HCV service for PWUDs at a large drug treatment centre in Brighton. From 2013-2021, a community nurse offered community-based HCV screening/treatment and non-invasive assessment of liver scarring, working alongside peer mentors and social workers delivering a non-judgemental/personalised and holistic service. The VALID study (2015-2018) was a similar model of care based at homeless hostels in Brighton. Finally, the END-C study (2019-2022), also based at homeless sites, extended our work to other sites in Sussex.

Goal and description of the intervention

The overall aim was to provide an integrated and comprehensive service based at drug treatment centres and sites for homeless people (hostels, day centres and shelters) to increase linkage to care. The Brighton and Sussex Medical School and Brighton and Sussex University Hospital collaborated with drug service providers and homeless shelters and delivered the following services:

- BBV screening using dry blood spot testing, oral swabs and venous blood;
- non-invasive assessment of hepatic fibrosis using potable Fibroscans®;
- assessment of alcohol (AUDIT) and substance misuse with onwards referral to key workers and general practitioners;
- access to OST and needle exchange;
- on-site psychiatrist;
- community-based HCV treatment with novel strategies to deliver DAA (at home, homeless sites);
- novel strategies to store DAA at sites for homeless people (setting up of personalised lockers);
- training staff at drug treatment centres and sites for homeless people to perform BBV screening as well as supervise DAA therapy;
- availability of peer mentors;
- engagement with social services.

Results and evidence of impact

Increased access to and treatment for HCV

Until June 2018, ITTREAT and VALID studies have linked 700 homeless people and PWUD into care in Brighton and Hove area. The number of PWUDs and homeless people referred from the community and receiving treatment increased from zero in 2011 to 153 in 2018. The intensive support provided by the HCV nurse means that service users are more open to being tested and are more informed about treatment options.

In Brighton & Hove, the percentage of PWUDs tested for HCV has increased from 87.6% in 2012/13 (prior to ITTREAT project) to 96.4% in 2017/18 (5 years into ITTREAT project), which represents the highest rate in South East England. Mortality from advanced HCV-related liver disease, including liver cancer, has reduced by 48% from 2012-2014 to 2016-2018, compared to a 9% reduction in mortality nationally. ITTREAT and VALID studies were the only clinical research conducted in the area during this period, specifically targeted at improving HCV testing and treatment of this high-risk population. The Sussex/BSMS HCV care model has since been adapted to other specialist services in the area.

Improved HCV care experience, understanding of HCV, and other health related outcomes

The community-based HCV cure was associated with a significant improvement in health-related quality of life indicators. Patients with HCV cure reported improved mental health, decreased distress and, most importantly, a

reduction in the stigma associated with HCV. This innovative model of care also contributed to an improved treatment experience in this group with the trusting client-provider relationship being instrumental in the individual's recovery pathway and their own health awareness. By providing a simplified HCV care pathway, patients experienced benefits over and above that related to the liver. It thus provided people who inject drugs with the opportunity to regain control of their health. It also had a significant impact on their understanding of the disease and their ability to access treatment. As a result, once treated for HCV, patients were able to address other issues in their lives such as their drug or alcohol use.

Provision of a good practice care model for healthcare professionals in HCV care

The Sussex holistic model of HCV care was commended by National Health System England in 2018 as a great model to replicate around the country. The initiative was among the first to establish community services specifically for HCV, confirming successful care for the high-risk population in community settings was possible. The other key point was the use of Fibroscan® in community clinics allowing focus not only on HCV care but also on liver disease in general. Consequently, Sussex ODN treats the highest number of people with HCV in drug treatment centres nationally, representing >20% of all treatments. In 2016-17, 11% of the Sussex ODN patients were treated in the community, with the majority of them in Brighton, but as of 2019-20, approximately half of the ODN patients are treated via the community-based HCV services. This has become the principal HCV service delivery within the Sussex ODN.

Annual reports are provided to ODN and Ethics Committee and internal evaluation report to ODN on an annual basis.

Transferability and sustainability of the intervention

The Sussex HCV model has been endorsed as Good Practice Model by the British Association for Study of the Liver and prominent charities such as HCV Action, hosting the ITTREAT case study and business case template on their websites for other ODNs to consult. Birmingham and Nottingham ODNs – two of the largest ODNs in England – adopted the Sussex HCV care model. The model has been presented at multiple local, regional, national and international meetings.

'Engaging the disengaged' is a regular programme, linked to the HCV elimination initiative in England. Initially, it has been funded by research grants (national and regional funding) as well as pharmaceutical industry, but positive impact resulted in hospital trust funding the nurses thus ensuring sustainability.

The main success factors of 'Engaging the disenganded' model were considered to be:

- collaboration with drug treatment specialists, pharmacists, social workers, peer mentors, general practitioners, qualitative researchers, health economists, charities (HCV Trust and HCV Action), social services and Commissioners;
- integrated and multidisciplinary approach with provision of all components of the service at one site;
- experienced community hepatitis nurse additionally trained in substance misuse and passionate about working with this client group to provide holistic care;
- easy access to nurse (mobile phone) and close supervision by a hepatologist;
- flexible 'drop-in' clinic appointments in contrast to the inflexible, non-personalised and stigmatised environment in secondary care;
- ongoing alcohol and drug use not a bar to HCV treatment;
- provision of peer mentors to support clients throughout their treatment journey;
- good engagement between key workers, drug and alcohol team, psychiatrist, peer mentors and hepatitis nurse;
- non-judgemental and holistic approach.

Positive outcome results show that such an intervention is feasible and can be used by organisations to develop and sustain such models of care. It generally requires a re-thinking of how HCV care is delivered, a relocation of existing staff and capacity building in the community.

Participation and inter-sectoral collaboration

Relevant partners in the development of the initiative have been staff at drug treatment centres and harm reduction services including NSP and homeless hostel staff. Setting up the service involved developing a clinical room as well as train staff on HCV, BBV screening and need for referral. GP helped set up service at hostels for homeless people and encouraged patients to attend. Staff at hostels for homeless people and national HCV charities as well as local Commissioners were also involved in the original set up of the study projects.

Relevant partners in the delivery of intervention are drug treatment centres and hostel staff for homeless people for the delivery of the service, GPs trained in motivational interviews to help clients with alcohol and substance misuse, pharmacies in delivery of DAA, labs in rapid turnaround of PCR/genotype, peers trained to perform BBV screen and supported clients during their HCV journey.

The success of the model is seen due to collaborative working with a robust network of drug treatment specialists, pharmacists, social workers, peer mentors, General Practitioners, qualitative researchers, health economists, charities (HCV Trust and HCV Action), social services and Commissioners. Key to implementation was regular reiteration, evaluation and feedback across the network, utilising 'Plan, Do, Study, Act' cycles to evolve solutions to the needs of each provider and their clients.

C. Interventions to increase adherence to treatment of infections among people who inject drugs

Table 6. Overview on models of good practice to increase adherence to treatment

	Name of project	Affiliation	Country	Infection(s) addressed
C.1	Comprehensive care of patients with substance use disorders	Addiction Research Group (GRAd). Instituto Hospital del Mar d'Investigacions Mèdiques, Barcelona	Spain	HIV/AIDS
C.2	HepLink arm of the HepCare Europe EU-funded project	University College Dublin	Ireland, United Kingdom, Romania, Spain	HCV
C.3	REACH-U – Point-of-care hepatitis C antibody and RNA testing and linkage to care to enhance uptake of treatment in outreach settings	CRESCER - Associação de Intervenção Comunitária	Portugal	HCV
C.4	Mobile Outreach Programme	Associação Ares do Pinhal	Portugal	HBV, HCV, HIV/AIDS, TB

C.1 Comprehensive care of patients with substance use disorders and HIV infection

Author Gabriel Vallecillo
Affiliation Addiction Research Group (GRAd), Instituto Hospital del Mar d'Investigacions Mèdiques, Barcelona, Spain.
Country Spain
Infection addressed HIV/AIDS

General information on the overall project/programme

The initiative has started in 2005 and has been an ongoing local regular programme in Barcelona/ Spain, which aims to provide comprehensive care for patients with substance use disorders and HIV infections, implemented into routine clinical care of an outpatient treatment centre. It is addressing current and former people who inject drugs, in particular people in OST, migrants/asylum-seekers, the youth and people without housing.

Background/rationale

The epidemic of dependence on illicit drugs, especially heroin, began in Spain in the late 1970s. By 1980, the incidence of heroin use had peaked [15]. In addition, the epidemic of human immunodeficiency virus (HIV) infection started in the 1980s. According to estimates, Spain reached its highest incidence of HIV infection related to the injection of illicit drugs in 1984: 79 cases per 100 000 inhabitants. The implementation of harm reduction programmes and opioid agonist therapies has reduced the HIV diagnosis and related mortality among people who inject drugs.

Goal and description of the intervention

The overall objective of this intervention is to increase the diagnosis, adherence and virologic response to HIV infection among people with substance use disorders independent of the administration route, which is predominantly intravenous in Spain.

The intervention is based on patient-centred care through a multidisciplinary comprehensive programme, including medical HIV care, substance use disorder treatment and psychosocial support at a drug outpatient drug treatment centre. The multidisciplinary health team includes a psychiatrist, a physician, a social worker, a psychologist, and trained nurses. This team designs, according to the individual's characteristics, the drug abuse treatment modality most suitable for each case (i.e. detoxification, opioid agonist therapy, inpatient detoxification referral, or residential treatment). Individuals are monitored on a regular basis in a multidisciplinary session to discuss the relevant issues for every individual. The communication between patients and the staff takes place within a framework of confidence, in an empathetic, non-judgmental, and non-punitive style, and with the regular use of motivational interviewing.

Psychiatric management of patients includes monitoring of their clinical condition and treatment response, as well as non-specific elements of psychotherapeutic relations (empathy, education). Psychopharmacological treatments (antidepressants, antipsychotics, anxiolytics and mood stabilisers) are prescribed as required.

The physician is a specialist in internal medicine and takes care of the individual's health problems, in particular the HIV-1 infection, tuberculosis prophylaxis or treatment, and hepatitis co-infection and prevention. He assesses when to initiate, the type, and the monitoring of antiretroviral therapy, which is free of cost and provided monthly at the centre.

The nurses dispense the methadone, carry out blood tests, and supervise urine tests. They review the side effects of medication, including methadone pharmacokinetic interactions, identify adherence problems, provide education on adherence, and when an individual patient does not attend the scheduled visits, they are responsible for locating the subjects and ensuring that they come to a return visit to secure patient retention.

Results and evidence of impact

Virological response is similar to the response of people treated in specialised healthcare facilities

Effectiveness of ART administered to active drug users through the comprehensive care approach in the drug treatment centre in Barcelona was assessed by Sánchez et al (2012). They compared the HIV treatment outcomes, measured as percentages of subjects reaching virological response (HIV-1-RNA <50 copies/ml), in a group of 71 ADU versus a control group of 48 matched subjects infected through sexual transmission and treated in the infectious diseases clinic (standard of care group). Both groups achieved high rates of viral suppression during a median follow-up of 118 weeks (range 24-252), of 87.3% (62/71) in the ADU group and 87.5% (42/48) in the standard of care group (P=.1779) [16].

Useful to reach the UNAIDS 90–90–90 target:

The comprehensive care model delivered at the drug-use treatment facility proved effective to reach the 90-90-90 cascade of care targets. From a total of 221 people who inject drugs monitored at the facility, all (100%) had the HIV status established. Of the 84 HIV-positive people who inject drugs, during a median follow-up of 98 months (interquartile range: 61–143), all (100%) received antiretroviral therapy and 76/84 (90.5%) achieved viral suppression [17].

Decreased patient-initiated, non-structured interruptions of antiretroviral therapy:

Among 132 people who inject drugs living with HIV who received HIV care as part of comprehensive care approach at the drug treatment centre, 37 (28%) experienced the first non-structured treatment interruption during a median follow-up of 53.8 months. Drug abstinence was indicated as essential for the long-term maintenance of cART [18].

Transferability and sustainability of the intervention

The submitter considers the strategy generally as transferable but highlights that there might be difficulties in the provision of ART and availability of viral load testing at drug treatment centres.

The main success factors of comprehensive care intervention were considered to be:

- integrated and coordinated care;
- motivation of professionals and specific training in drug treatment medicine;
- confidential, respectful and non-judgemental physician-patient relationship; and
- the clinical setting is near to the neighbourhood where clients reside and access is free.

Participation and inter-sectoral collaboration

Relevant collaborators in the development and delivery of the initiative were drug treatment and healthcare providers as well as local pharmacies.

The most important aspect of this strategy is the patient and not the disease. The multidisciplinary approach of all issues of the patients (substance use, psychological problems, and social problems) benefits indirectly the success of antiretroviral therapy for HIV infection. Furthermore, the strategy avoids fragmentation of clinical care and subject loss to follow up during referral to HIV care to another clinical setting. Additionally, this intervention is used for prevention and diagnosis of other infections, particularly hepatitis C and tuberculosis.

C.2 HepLink arm of HepCare Europe

Author	Geoff McCombe
Affiliation	University College Dublin
Countries	Ireland (Dublin), United Kingdom (London), Spain (Seville), Romania (Bucharest)
Infection addressed	HCV

General information on the overall project/programme

HepLink study was an arm of the EU-funded international research project HepCare EUROPE, involving partners from Ireland (Dublin), United Kingdom (London), Spain (Seville) and Romania (Bucharest). The Dublin-based project started in April 2016 and in October 2019 it was implemented in all 4 participating sites. The HepLink integrated models of HCV care focused on HCV diagnosis and treatment in vulnerable populations, including current and former people who inject drugs in low-threshold settings, OST, prison as well as outreach programmes.

Background/rationale

The HepLink study examined feasibility, acceptability and likely effectiveness of enhanced linkage and adherence to treatment for people who inject drugs of the developed model of integrated care for HCV.

A pre- and post-intervention design was used to establish the feasibility, acceptability and likely effectiveness of the HepLink model of care to enhance HCV identification, and linkage and adherence to HCV treatment among people who inject drugs attending primary care and community-based services. Pre- and post-intervention data were collected on participating patients to examine HCV care processes before and after the delivery of the HepLink nurse intervention. In addition, data were collected on study recruitment, retention and implementation of the model of care components.

Past 12-month data on all of the above variables was also collected at the four sites. Post-intervention, follow-up data were collected at all sites via manual review of participants' clinical records and included past 12-month and lifetime data on all of the above variables. While this study was not powered for formal testing of intervention effectiveness, the possible impact of the intervention was measured by examining the proportion of participants pre- and post-intervention who had ever received each step in the HCV cascade of care.

Goal and description of the intervention

The HepLink model of integrated care was tailored to health service infrastructure and population health needs locally at the four EU sites. It consisted of three key interventions:
(i) outreach of an HCV-trained nurse into primary care and community services to provide clinical support and facilitate referral of people who inject drugs to infectious diseases services;
(ii) enhanced community-based HCV evaluation of patients (including on-site Fibroscan® where feasible to stage liver fibrosis);
(iii) HCV education for primary and community care practitioners and patients.

The HepLink study was conducted in OST-prescribing clinical services based in the community and in primary care.

Results and evidence of impact

To measure feasibility, the numbers of recruited and retained primary care and community-based services and patients at each of the four EU sites were recorded. To measure acceptability, uptake of the model of care components were recorded, i.e. (i) HCV nurse outreach/clinical support; (ii) enhanced community-based HCV evaluation of patients (including on-site Fibroscan® where feasible); and (iii) practitioner education. Prior to the delivery of the HepLink nurse intervention at each service, baseline data on patient demographics and prior HCV care were collected from participants' clinical records and/or from patients' self-reports via researcher-administered questionnaires to measure likely effectiveness.

Twenty-nine primary care and community-based health services and 530 patients were recruited. Baseline data were collected on all participants. Prior lifetime HCV antibody testing ranged from 65% (Bucharest) to 95% (Dublin) and HCV antibody positivity among those who had been tested ranged from 78% (Dublin) to 95% (Bucharest). Prior lifetime HCV RNA testing among HCV antibody-positive participants ranged from 17% (Bucharest) to 84% (London). Among HCV antibody- or RNA-positive participants, prior lifetime attendance at a hepatology/infectious disease service ranged from 6% (London) to 50% (Dublin) and prior lifetime HCV treatment initiation from 3% (London) to 33% (Seville).

In conclusion, baseline assessment of the HCV cascade of care among people who inject drugs attending primary care and community-based health services at four European sites identified key aspects of the care cascade at each site that need to be improved. [19]

Periodic reports at 12, 24 and 42 months were submitted to the European Commission; regular internal evaluations of progress were conducted through steering group meetings and international advisory board meetings. Peer reviewed publications are available.

Transferability and sustainability of the intervention

The submitter highlights that this intervention is scalable and transferrable.

While the main success factors of HepLink intervention were not reported, the submitter indicated the following benefits of the intervention:

- Assessment of the HCV cascade of care among people who inject drugs attending OST prescribing primary care services and other community-based health services at four European sites; that is crucial for evaluating where improvements to the care cascade are needed.
- The study provides a benchmark for enhancing linkage and adherence to treatment for people who inject drugs through testing, referral and treatment.

The study was financially supported by the European Commission through its EU Third Health Programme and Ireland's Health Services Executive.

Participation and inter-sectoral collaboration

Relevant partners in delivery of the activities have been OST-prescribing clinical services based in the community and in primary care.

C.3 REACH-U - Point-of-care hepatitis C antibody and RNA testing and linkage to care to enhance uptake of treatment in outreach settings

Author	Christiana Merendeiro
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Country	Portugal
Infection addressed	HCV

General information on the overall project/programme

CRESCER is a local low-threshold service, providing outreach services for approximately 2 000 PWUD per year, including 500 with recent injecting drug use, operating daily in the urban areas of Lisbon with high levels of drug consumption.

Barriers for attending specialist-based appointments in hospitals has led to suboptimal RNA testing and uptake of HCV therapy. In order to increase involvement in HCV care cascade, CRESCER initiated the pilot project 'REACH-U' in August 2020, which is implemented in low-threshold settings, outreach programmes (shelters) addressing current and former people who inject drugs with a specific focus on people in OST, migrants/asylum-seekers, MSM and youth who inject drugs (15-24 years). The project will continue until December 2022.

Details on the 'REACH-U' initiative to enhance community-based testing are provided in A.2 and to increase linkage to care in B.3.

Background/rationale

In Portugal, in 2019, approximately 25 000 people were living with chronic HCV infection. Most cases of HCV infection occur among people who inject drugs [6,7]. Among current people who inject drugs, the proportion of people living with HCV infection is estimated to be 66%. Among people in outreach, the prevalence varies between 18% (new participants), 37% (readmitted participants) and 79%–82% (people who have a history of injecting drug use) [8].

Since October 2018, CRESCER has been running a point-of-care (POC) HCV antibody testing intervention combined with nursing and peer-based outreach to enhance HCV testing and treatment among vulnerable groups. The intervention is aiming to meet socially isolated people who inject drugs in their own environment (e.g. areas with high levels of drug consumption), who refuse to leave the neighbourhoods and do not access other health services, including low-threshold or outreach services, e.g. opioid substitution treatment, mobile testing units or shelters. Between October 2018 and July 2020, 142 participants were enrolled. Overall, 37% (52 of 142) were HCV antibody positive and referred for specialist assessment. Only 37% (19 of 52) attended a specialist appointment. Among the 10 people with detectable HCV RNA, 40% (n=4) initiated treatment.

In August 2020, CRESCER implemented the pilot project REACH-U to enhance HCV testing and treatment uptakes and began to implement HCV RNA testing outside of clinics in areas where the target population is located.

Goal and description of the intervention

The overall goal was to increase the HCV treatment uptake and guarantee medical compliance and adherence to medicine for PWUD and other vulnerable population groups, such as people without housing, asylum-seekers, and migrants, with whom CRESCER works in related projects. In the future, this initiative is intended to integrate other low-threshold and outreach services, like shelters.

To increase adherence of people who inject drugs to HCV treatment a medical procedure has been set up, which is completely provided in the community. The person therefore does not need to go to the hospital. A peer navigator assists in promoting treatment adherence and foster patient's trust in healthcare. After medication is available (currently, hospitals are taking an average of three months minimum), the CRESCER outreach team pick up the monthly medication and provide it to the participants on-site to maximise adherence. In some cases, provision of daily medication on-site through DOT is implemented, as the team already does with tuberculosis drugs, antiretroviral drugs and antibiotics. Visits are conducted at the end of treatment and 12 weeks following treatment to determine treatment success.

Results and evidence of impact

The following impact indicators have been defined for community-based testing (indicators for Community-based testing and Linkage to Care are provided in A.2 and B.3):

- proportion of participants with undetectable HCV RNA at 12 weeks following the end of treatment (SVR12) with direct-acting antiviral (DAA) therapy;
- proportion of participants who complete treatment;
- proportion of participants with undetectable HCV RNA at the end of treatment; and
- proportion of participants who engage in follow-up HCV RNA testing.

At the beginning and at the end of each individual participation in the project a participant-administered survey will be conducted. A non-randomised trial is planned to evaluate this intervention. In addition, an execution report to funding bodies for quality assessments is published.

No metrics have been reported due to the recent implementation of the pilot project REACH-U in August 2020. Although effectiveness could not be documented at the time of submission, the general consensus of the Expert Panel was to include the pilot project as a relevant model of intervention.

Transferability and sustainability of the intervention

The submitter considers the initiative as transferable to other national harm reduction and/or outreach services and prisons, if there is political will as well as appropriate flexibility of healthcare services. Existing harm reduction service approaches is a pre-condition of implementing it in other countries.

REACH-U is conceptualised as a pilot project and funded by specific national and regional funding as well as co-funded by a pharmaceutical company. The work of REACH-U is directly linked to the Portuguese national programme for viral hepatitis, 2017 report '[Programa nacional para as Hepatites Virais]'.

In order to sustain the intervention, the submitter identifies a need in development of outreach work and guaranteed outreach workers specialised training. Flexible procedures based on a harm reduction approach need to be implemented and a good collaboration with the healthcare system needs to be ensured to facilitate access to appointments and treatment for people who inject drugs. The implementation of peer navigators is also considered as crucial for the sustainability of the intervention.

Furthermore, REACH-U indicates the establishment of public and private collaborative partnerships, advocacy campaigns that involved inviting public and private institutions to the field and the constant search for public and private financial support as core for the success of the intervention.

Participation and inter-sectoral collaboration

Relevant partners in the development of the overall initiative have been peer workers, ensuring the coverage of target population's needs. CRESCER's multi-disciplinary team and long-time outreach working experience help to identify barriers to community-based testing and interventions and to develop strategies to overcome challenges. People with gastroenterology expertise have been involved in for clinical and research advice and a pharmaceutical company for clinical advice.

Holding a key role in delivery of the overall REACH-U activities are peer navigators to enhance participation in HCV screening and facilitate linkage to care and treatment and prevention of re-infection, a specialised outreach team with two harm reduction service providers, namely a nurse and a peer, as well as a medical doctor specialised in prescribing DAA therapy from Gastroenterology Service – Santa Maria Hospital (Lisbon).

C.4 Adherence to treatment of infections among people who inject drugs on a mobile outreach programme

Author	Elsa Belo
Affiliation	Associação Ares do Pinhal
Country	Portugal
Infections addressed	HBV, HCV, HIV/AIDS, TB

General information on the overall project/programme

Ares do Pinhal is a Lisbon-based drug treatment centre, which provides low-threshold services, OST programmes and mobile outreach programmes (MOP) to people who currently and formerly use drugs. The MOP includes three vans (two dedicated to OST and one with a focus on medical care and psychosocial support) that work directly in the community setting, with regular and permanent stops in the most strategic hotspots in Lisbon near at-risk communities. Generally, the main attributes of the MOP include improved access to healthcare, linkage to care with simplified admittance and social support, promotion of better living standards and general health, a low-threshold OST programme and a NSP programme, comprising additional safe use equipment. The MOP started an infectious diseases initiative in 2006 with a duration until December 2022, particularly addressing people in OST, migrants/asylum-seekers, people without housing and people who live with chronic infectious diseases. The initiative includes prevention, screening for infectious diseases, linkage to care, treatment and prevention of reinfection and relapse.

Details on the MOP initiative to enhance community-based testing are provided in A.5 and to increase linkage to care in B.2.

Background/rationale

One of the targets of the MOP is the provision of measures that cover health needs of people who use drugs/people who inject drugs as well as a constant monitoring of potential health threats of its clients. In this context, infectious diseases are a concern as PWUD, in particular people who inject drugs, are at a higher risk of contracting HCV, TB, HBV, and HIV. Data from 2016 gathered by MOP indicate a much higher HCV prevalence among the users in the programme (67.6 %) than in the general population. Infectious diseases among people who inject drugs have already been prevalent/ detected in the 1990s among, at that time, a young user population (21.4% HBV prevalence; 83% HCV prevalence). Most of these clients are in their 50-ties nowadays and previous infections increased healthcare costs with hepatocellular carcinoma, one of the consequences of HCV infection, in Portugal. The introduction of direct-acting antivirals (DAAs) with a treatment efficacy around 97% and an adequate safety profile with high tolerability allowed for better treatment adherence and clinical outcomes in these patients.

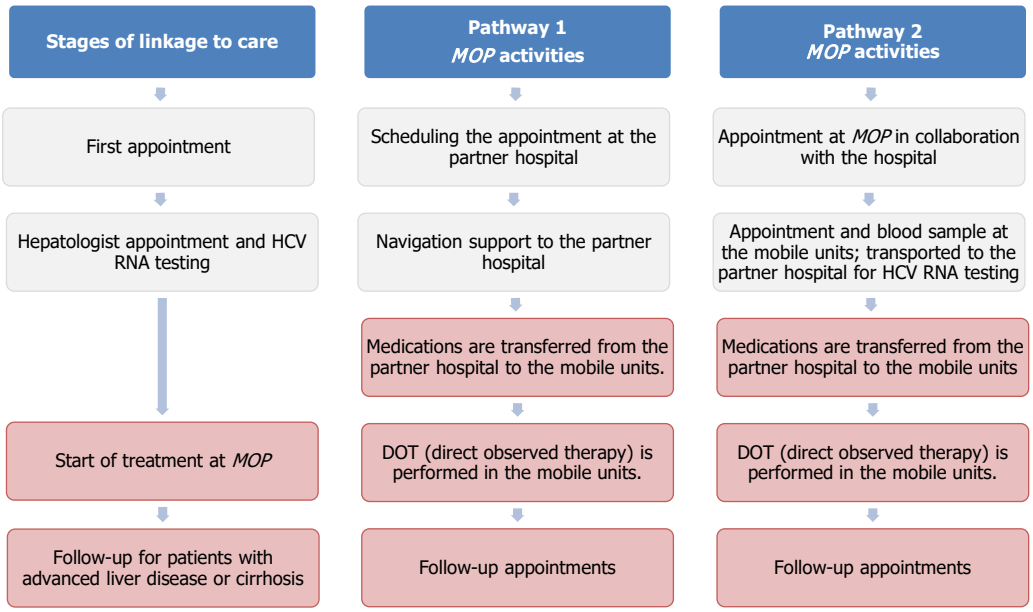
Goal and description of the intervention

The MOP provides a comprehensive low-threshold approach that includes prevention, screening for infectious diseases, linkage to care, treatment and prevention of reinfection and relapse. Experiences showed that the lack of proper screening and confirmatory diagnosis are major challenges to tackle, namely in people who inject drugs population. The MOP comprises screening for HCV and other infectious diseases (based on blood tests and radiography) at programme admission and on a regular basis (see A.5). In order to increase linkage to care for infectious diseases among people who inject drugs, patient referral to other healthcare services that provide confirmatory diagnosis and treatment prescription is also within the scope of the project (see B.2).

The MOP facilitates access to treatment through a close partnership with local hospitals and other healthcare institutions. The initiative has all relevant clinical and psychosocial support personnel (doctors, nurse, psychologists and social workers). The low-threshold approach reduces the obstacles posed by the main healthcare access barriers and promotes a close relationship with the users. In addition, the participation of peer workers and other awareness and inclusion activities facilitate in accomplishing the goals of the program. In order to meet the needs of the clients as much as possible, diverse pathways for care are offered.

MOP follows a comprehensive and collaborative approach, which distinguishes between two pathways for HCV treatment. Crucial steps concerning adherence to treatment are highlighted (see red boxes in Figure C.4).

Figure C.4. Distinct pathways to increase adherence to treatment for HCV treatment through the Mobile Outreach Programme



Results and evidence of impact

From 1 January 2018 to 30 June 2020 a total of 2 322 users were enrolled in the program and offered testing for HBV, HCV, HIV and TB. Numbers of people who inject drugs linked to care from of those that tested positive were presented in Table B.2. Indicators for adherence to treatment are presented in Table C.4.

Table C.4. Indicators for adherence to treatment between 01/2019 and 06/2020

Indicator	HBV	HCV	HIV/AIDS	TB
Number of people who inject drugs with a positive test result	15	241	123	20
Number of people who inject drugs who started treatment	1	153	118	20
Number of people who inject drugs who are currently undergoing treatment	1	1	43	3
Number of people who inject drugs who completed treatment (or on treatment for HIV)	0	152	75	15

To monitor the project, monthly reports for relevant stakeholders, a weekly meeting to assess the outcomes and evaluate needs of adjustments and external process evaluation aiming to improve strategic long-term objectives are performed.

Transferability and sustainability of the intervention

Transferring this intervention to other countries must ensure that the PWUD are regarded as patients. Legal constraints may apply in other countries. Decriminalisation of drug use, a coordinated effort with relevant stakeholders, and the physical proximity to the community, provided by the mobile units, is paramount to the project's success.

The MOP is a regular programme of the drug service centre Ares do Pinhal and therefore an integrated part of the general budget of the facility based on regional and local funding, additional funding is provided by pharmaceutical industry.

The work of MOP is directly linked to the following policy strategies:

- WHO targets to eliminate HCV infection;
- Operational Plan for Integrated Responses (PORI) (Plano Operacional de Respostas Integradas – PORI), which is based on the principles of territoriality, integration, partnership and participation that constitute the strategic orientation framework defined by the ILO, in the context of the fight against poverty and social exclusion;
- National vaccination plan (Plano Nacional de Vacinação), with a special focus on TB, HBV and Influenza (in the case of homeless clients);

- National Programme for Viral Hepatitis (Programa Nacional para as Hepatites Virais), which is focused on addressing vaccination and treatment of viral hepatitis;
- National Programme for HIV and AIDS Infection (Programa Nacional para a Infeção VIH e Sida).
- National program for syringe exchange has provided much needed support for people who inject drugs though the exchange and distribution of syringes;
- As Lisbon region is one of the most problematic areas in Europe concerning TB, MOP is also included in the network of the National Programme for Tuberculosis (Programa Nacional para a Tuberculose).

The main success factors of MOP intervention are considered to be*:*

- The integrated approach, from screening to treatment follow-up, and the inclusion in the community setting.
- The experience of over 30 years in working with people who use drugs/people who inject drugs at Ares do Pinhal that increases the capability of establishing meaningful and trusting relationships with drug users. Considering the drug users as patients provides a different perspective from what is commonly seen in other settings, with a strong focus on harm reduction and public health. The low-threshold OST is important for the development of a relationship that improves treatment adherence and compliance, as well as the NSP.
- The MOP's team seasoned competences for clinical and psychosocial support and, the partnership with peers and relevant stakeholders such as physicians, local hospitals, pharmaceutical industry, and others (SICAD, Lisbon City Council).

Participation and inter-sectoral collaboration

Relevant partners in the development of the initiative have been SICAD and the Camara Municipal de Lisboa, both in the funding of the project and monitoring of work. In addition, peers were actively involved in the development of the programme by sharing their personal experience with MOP's staff. Some peers are part of the MOP team and thus fulfilling a crucial role in the conceptualisation of activities that meet the needs of the target population.

Relevant partners in delivery of the activities are SICAD, the national HIV/AIDS programme, the national programme for HIV/AIDS, Hepatitis and Tuberculosis infection, providing safe use equipment and information material for the target group, Instituto Nacional de Emergência Médica (INEM) for support in medical emergency situations, drug treatment service providers (withdrawal unit to promote access to more structured treatments and local drug service provider for further admission) as well as alcohol treatment units, and specialised infection diseases centres providing screening for HIV, hepatitis, syphilis as well as TB. In addition, primary healthcare centres, hospitals, and hospital pharmacies in case of hospitalisation, prisons to ensure OST during detention as well as street teams, therapeutic communities, shelter/ housing centres, social services are interconnected with MOP. Community groups are part of local councils to promote the work within the community, to identify at-risk people who inject drugs and facilitate the access to community resources. Peers facilitate the interaction with current people who inject drugs, by integrating the activities and promoting a trusting environment.

Partnerships have been clearly extended allowing for a deepening of technical relations and collaborative actions. It was also possible to involve new community partners, who proved effective to solve problems related to addictive behaviours and their consequences in the community.

D. Health promotion interventions to prevent infections among people who inject drugs

Table 7. Overview on models of good practice on health promotion interventions to prevent infections among people who inject drugs

	Name of project	Affiliation	Country	Infection(s) addressed
D.1	Guidelines for the screening and early diagnosis of drug-related infectious diseases	Istituto Superiore di Sanita	Italy	HBV, HCV, HIV/AIDS
D.2	Decentralising needle exchange	Office of Addiction and Drug Policy of Vienna	Austria	HBV, HCV

D.1 Guidelines for screening and early diagnosis of drug-related infectious diseases

Author Barbara Suligoi
Affiliation Instituto Superiore di Sanità
Country Italy
Infections addressed HBV, HCV, HIV/ AIDS

General information on the overall project/programme

The initiative, started in January 2015, with the development of national 'Guidelines for screening and early diagnosis of drug-related infectious diseases'. It was promoted and financed by the Presidency of the Council of Ministers Department for Anti-Drug Policies/Italy and the guidelines were published in 2017. The aim of the initiative is to increase the screening of people who inject drugs, particularly in low-threshold drug services and people who inject drugs in OST, by providing health professionals in all Italian regions with a specific training.

Background/rationale

In Italy, HIV, HBV, and HCV infection are highly prevalent among PWUD (8%, 35%, and 60%, respectively). However, in drug treatment centres, testing rates for these infections are low (around 70%). This evidence prompted the elaboration of guidelines, which are intended for healthcare personnel and aimed at promoting the prevention and treatment of HIV, HBV, HCV, and syphilis in low-threshold public drug treatment services.

The guidelines 'Nuove Linee di indirizzo per lo screening e la diagnosi delle principali patalogie infettive correlate all'uso di sostanza neu Servizi per el Dipendenze' (2017) recommend screening for these infections of people who use or have used drugs, who should be actively offered serological testing every six to 12 months, along with targeted pre- and post-test counselling, specific prevention measures, and linkage to care and treatment for those who need it. The guidelines were developed by the National Institute of Health in collaboration with the Drug Prevention Policy Department, regional representatives of drug treatment services, and representatives of the community of people who use drugs.

Goal and description of the intervention

Following specific training on guidelines for screening and early diagnoses of drug-related infectious diseases, healthcare professionals in low-threshold facilities can contribute to increasing awareness among people who inject drugs about the risk of communicable diseases associated with injecting drug use, the uptake and/or coverage of prevention services and the testing for infections among people who inject drugs in specific. Further, people who inject drugs can improve knowledge about prevention of infections and the adherence to prophylactic approaches.

The intervention addresses healthcare professionals working in treatment service centres. For a sustainable implementation of the Guidelines' recommendations, healthcare personnel working in low-threshold drug treatment services for people who inject drugs from all Italian regions were invited to participate in a two-day training course aimed at providing recommendations for implementing testing, suggestions to overcome organisational issues, and a model for targeted counselling. In addition, the concept follows a train-the-trainer approach to further distribute the information within the particular low-threshold services.

A final document entitled 'Guidelines for screening and early diagnosis of drug-related infectious diseases' was published in 2017 and disseminated online.

Results and evidence of impact

In total, 39 healthcare personnel working in low-threshold services as well as in OST, at least one person from each of the 22 Italian regions, one NGO representative, and 20 training staff members were attending the training. Every participant has been in charge of training in turn approximately five healthcare personnel working in their own drug treatment centre. Therefore, it is estimated that around 200 healthcare workers have been trained.

The guidelines have been actively disseminated by e-mail to more than 550 managers of drug treatment centres, various scientific societies in the field of drug addiction, and a few NGOs involved in drug prevention. Since its publication, the guidelines have been downloaded around 650 times per year from the website.

To estimate the impact of the intervention the proportion of PWUD tested for HIV, HBV, and HCV in 2017 (year of the training course) and those in 2018-2019 have been compared. The proportion of people tested in drug treatment centres slightly increased for both HBV (19% vs 21%) and HCV (18% vs 20%) in 2018 and remained stable in 2019. For HIV, the proportion decreased from 38% to 30% because four large regions did not send or sent partial data to the surveillance system (source: Relazione Annuale al Parlamento). A cross-sectional survey is planned to further monitor changes in these proportions.

Transferability and sustainability of the intervention

Concerning the transferability, the submitter highlights that the development process, the guidelines, and the training can be taken as a model that can be replicated in other countries.

Specific national funding has been provided for the development and the dissemination of the Guidelines. In order to sustain the intervention adequate funding should be dedicated to implementing the Guidelines recommendations, and to performing a periodical evaluation of the testing and management recommendations.

For the successful implementation of the initiative participation and agreement on the final document between regional representatives of drug treatment services, Ministry of Health, Drug Prevention Policy Department, NGOs, and community people was important.

Participation and inter-sectoral collaboration

Relevant partners in the development of the initiative have been regional representatives of drug treatment services, members of the community of people who use drugs (peers) as well as NGOs involved in drug prevention. Relevant partners in delivery have been the Ministry of Health and the Drug Prevention Policy Department.

The submitter considers the discussion between different collaborators as extremely useful, in particular during the development of the Guidelines. It facilitated the integration of the skills of healthcare staff working in drug treatment services and the suggestions of people who personally experienced drug use in the public health's perspectives.

D.2 Decentralised needle exchange programme

Author	Mathias Tötzl
Affiliation	Office of Addiction and Drug Policy of Vienna (Sucht- und Drogenkoordination Wien)
Country	Austria
Infections addressed	HBV, HCV, HIV/ AIDS

General information on the overall project/programme

The decentralised needle exchange programme is part of a regular NPS initiative in Vienna aiming to continuously extend the access to sterile drug use equipment for people who inject drugs. Since 2019, the regular NPS programme is constantly adding new partners, namely local pharmacies, and homeless shelters, to expand this important public health intervention and better reach people who inject drugs in their daily environments. Within the initiative sterile injecting equipment is distributed free of charge.

Background/rationale

NSP, implemented in low-threshold settings, is considered as a very effective public health intervention to prevent infectious diseases among communities of people who inject drugs. Apart from sterile needles and syringes, additional drug consumption paraphernalia are distributed. The city of Vienna provides a very successful NSP programme with about 3.5 million distributed needles and a return rate of 98.2% in 2019. Up until recently, NSP was mainly available at two central locations, one of it available 24/7. The NSP programme is operated by Suchthilfe Wien gGmbH, a subsidiary of the city government, and is the only free of charge access to sterile drug consumption equipment in Vienna.

In order to expand NSP and facilitate accessibility and integration in the daily life settings of people who inject drugs, the city government decided to increase NSP locations throughout the city. This NSP expansion approach started in 2019, when pharmacies were contracted to provide needle exchange services to people who inject drugs. In early 2020, the programme expanded to various homeless shelters.

Goal and description of the intervention

The main objective of the intervention is to decrease the risk of acquiring infections, to increase safer drug use skills among people who inject drugs, and to promote NSP by targeting drug use behaviour (e.g. routes of administration) and raise awareness of infectious diseases prevention.

To increase the number of NSP sites spread across the city, a decentralised NSP programme primarily focussing on those settings, where people who inject drugs regularly visit, has been established. Several pharmacies, where OST is delivered often on a daily basis, as well as homeless shelters collaborating in the distribution of sterile injecting equipment, including a wide range of paraphernalia (e.g. stericups, filters, clean water) are included in the decentralised NSP programme. The service is free of charge for people who inject drugs; participating sites receive a financial compensation for their service.

For a successful implementation of the intervention, a specific training has been developed for staff working in participating institutions. The training is carried out by harm reduction experts of the regional harm reduction service in Vienna. Health promotion materials for people who inject drugs on safer use as well as information brochures for staff in participating locations is provided as well.

An important service to participating locations is the deployment of a custom-made needle exchange box, which goes along with continuous supply as well as waste logistics operated by Suchthilfe Wien.

Results and evidence of impact

Defined indicators are the following:

- number of equipment/ materials distributed; and
- infection rate among people who inject drugs.

Due to the recent start, the continuing expansion, and the additional difficulties caused by the COVID-19 pandemic, it is not yet possible to get conclusive numbers to show the impact of the programme. In addition, not all partners, in particular pharmacies, are able to document the number of contacts or exchanged materials. In those cases, the number of materials distributed to a particular site and the weight of the discarded needles and syringes is used for evaluation purposes.

It is expected to obtain numbers that are more conclusive in 2021, with a specific interest in determining whether the additional NSP locations result in a higher overall use of the NSP-services or if it mainly leads to a reduction of contacts at the existing NSP locations of the NPS programme.

Until now, a constant increase of the number of contacts at new decentralised NSP sites seems to be evident, highlighting that people who inject drugs are becoming aware of and are frequenting the new locations. From January to October 2020 there were already 10 000 exchanges in homeless shelters and pharmacies, which amounts to around 10% of all exchanges in Vienna.

The intervention is monitored through routine documentation and annual reports.

Transferability and sustainability of the intervention

The submitter considers this intervention as transferable, as homeless shelters and especially pharmacies are available in most European cities. There is a need for a central authority that oversees supply, training, and advice for participating institutions.

The initiative is funded by specific regional funding and included in the overall NSP provision budget in Vienna. The work of the decentralised needle exchange approach is directly linked to the 'Vienna Addiction and Drug Strategy', which includes an expansion of needle exchange services to Vienna's outer districts. From a project's perspective, a continuing commitment by the regional government for an integrated approach of infectious disease prevention within the general healthcare and social system is needed in order to sustain the intervention.

The main success factors of the intervention were considered to be:

- support provided by Suchthilfe Wien (training, supply, and initial set-up of exchange boxes) to minimise the effort for the partnering institutions;
- financial compensation received by pharmacies for their work;
- training, which was felt to be essential in reducing fears or misconceptions the staff may have in pharmacies and other decentralised settings; and
- the importance of providing different models or customised versions of the needle exchange boxes to suit the space available, especially for pharmacies.

Participation and inter-sectoral collaboration

Relevant partners in the development of the initiative have been the Vienna Addiction and Drug Coordination Office, the City Government of Vienna, Suchthilfe Wien, the Chamber of Pharmacists and the Vienna Social Fund. Relevant partners in delivery have been Suchthilfe Wien, multiple pharmacies across Vienna and providers of homeless shelters, namely Obdach Vienna, Red Cross Vienna, Caritas Vienna, Samariterbund Vienna, Neunerhaus.

References

1. European Commission Directorate-General for Health and Food Safety (DG SANTE). Criteria to select best practices in health promotion and chronic disease prevention and management in Europe. Brussels: DG SANTE; 2017. Available from: https://ec.europa.eu/health/sites/health/files/major_chronic_diseases/docs/sgpp_bestpracticescriteria_en.pdf
2. European Centre for Disease Prevention and Control (ECDC) and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Prevention and control of infectious diseases among people who inject drugs. Stockholm: ECDC; 2011. Available from: https://www.ecdc.europa.eu/sites/default/files/media/en/publications/Publications/111012_Guidance_ECDC-EMCDDA.pdf
3. European Centre for Disease Prevention and Control (ECDC) and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Evidence for the effectiveness of interventions to prevent infections among people who inject drugs. Part 1: Needle and syringe programmes and other interventions for preventing hepatitis C, HIV and injecting risk behaviour Stockholm: ECDC; 2011. Available from: https://www.ecdc.europa.eu/en/publications-data/ecdcemcdda-report-evidence-effectiveness-interventions-prevent-infections-among-0
4. European Centre for Disease Prevention and Control (ECDC) and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Evidence for the effectiveness of interventions to prevent infections among people who inject drugs. Part 2: Drug treatment for preventing hepatitis C, HIV and injecting risk behaviour. Stockholm: ECDC; 2011. Available from: https://www.ecdc.europa.eu/en/publications-data/ecdcemcdda-report-evidence-effectiveness-interventions-prevent-infections-among
5. European Comission (EC). Questions and Answers on the United Kingdom's withdrawal from the European Union on 31 January 2020. Brussels: EC; 2020. Available from: https://ec.europa.eu/commission/presscorner/detail/en/qanda_20_104
6. Silva JM, Silva MJ, Calinas F, Nogueira PJ. Burden of Liver Cirrhosis in Portugal between 2010 and 2017. GE Port J Gastroenterol. 2021;28(3):153-61.
7. Fernandes A, Martins H, Aldir I, Bettencourt J, Rodrigues J, Aleixo M. Programa Nacional para as Hepatites Virais. Lisbon: 2019.
8. Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (SICAD). Relatório Anual 2018 - A Situação do País em Matéria de Drogas e Toxicodependências. Lisbon: SICAD; 2019.
9. Aldridge RW, Hayward AC, Hemming S, Yates SK, Ferenando G, Possas L, et al. High prevalence of latent tuberculosis and bloodborne virus infection in a homeless population. Thorax. 2018;73(6):557.
10. Ward Z, Campbell L, Surey J, Platts S, Glass R, Hickman M, et al. The cost-effectiveness of an HCV outreach intervention for at-risk populations in London, UK. J Antimicrob Chemother. 2019;74(Suppl 5):v5-v16.
11. Surey J, Menezes D, Francis M, Gibbons J, Sultan B, Miah A, et al. From peer-based to peer-led: redefining the role of peers across the hepatitis C care pathway: HepCare Europe. J Antimicrob Chemother. 2019;74(Suppl 5):v17-v23.
12. O'Sullivan M, Jones A-M, Gage H, Jordan J, MacPepple E, Williams H, et al. ITTREAT (Integrated Community Test - Stage - TREAT) Hepatitis C service for people who use drugs: Real-world outcomes. Liver Int. 2020;40(5):1021-31.
13. Phillips C, Schulkind J, O'Sullivan M, Edelman N, Smith HE, Verma S, et al. Improving access to care for people who inject drugs: Qualitative evaluation of project ITTREAT—An integrated community hepatitis C service. J Viral Hepat. 2020;27(2):176-87.
14. Hashim A, Bremner S, Macken L, Worthley T, Aithal A, Verma S. FRI-231-Hostel-based models can prove the engagement of homeless individuals with liver services: VALID (vulnerable adults liver disease) study. J Hepatol. 2019;70(1)(Suppl):e496-97.
15. Torrens M, Fonseca F, Castillo C, Domingo-Salvany A. Methadone maintenance treatment in Spain: the success of a harm reduction approach. Bull World Health Organ. 2013;91(2):136-41.
16. Sanchez GV, Llibre JM, Torrens M, Sanvisens A, Mateu G, Knobel H, Langohr K, Santos JR, Muga R. Effectiveness of Antiretroviral Therapy in HIV-1-Infected Active Drug Users Attended in a Drug Abuse Outpatient Treatment Facility Providing a Multidisciplinary Care Strategy. Curr HIV Res. 2012;10(4):356-63.
17. Vallecillo G, Fonseca F, Marín G, Castillo C, Dinamarca F, Durán X, et al. Reaching the 90–90–90 UNAIDS treatment target for people who inject drugs receiving integrated clinical care at a drug-use outpatient treatment facility. J Public Health. 2020.

18. Vallecillo G, Mojal S, Roquer A, Samos P, Luque S, Martinez D, et al. Low Non-structured Antiretroviral Therapy Interruptions in HIV-Infected Persons Who Inject Drugs Receiving Multidisciplinary Comprehensive HIV Care at an Outpatient Drug Abuse Treatment Center. AIDS Behav. 2016;20(5):1068-75.

19. Nic An Riogh E, Swan D, McCombe G, O'Connor E, Avramovic G, Macias J, et al. Integrating hepatitis C care for at-risk groups (HepLink): baseline data from a multicentre feasibility study in primary and community care. J Antimicrob Chemother. 2019;74(Suppl 5):v31-v8.

Annex 1. Synopsis of models of good practice

Model of good practice title	Country	Infection addressed	Settings	Population	Type of intervention
Accelerating the TB/HIV response for key populations in EECA cities	Republic of Moldova	HIV/AIDS, TB	Low-threshold OST outreach programme	Current PWID; people in OST, young PWID, partner contacts, sex workers	Peer-based; multidisciplinary approach; cooperation
REACH-U – Point-of-care hepatitis C antibody and RNA testing and linkage to care to enhance uptake of treatment in outreach homeless settings	Portugal	HCV	Low-threshold; outreach programme	Current and former PWID; People in OST, migrants/asylum-seekers, MSM, young PWID, sex workers; people without housing; pregnant women	Nurse lead; peer-based; multidisciplinary approach; cooperation; DOT; contingency management; telemedicine
Belarusian Public Association 'Positive Movement'	Belarus	HCV, HIV/AIDS	Low-threshold; outpatient treatment centres	Current PWID; MSM; young PWID; Partner contacts; sex workers; pregnant women	Nurse lead; peer-based; multidisciplinary approach; contingency management; cooperation
Hepatitis C bus (HCV-bus)	Norway	HCV, HIV/AIDS	Low-threshold; OST; prisons; outreach programmes	Current and former PWID; people in OST, prisoners, people without housing	Nurse lead; peer-based; cooperation
Mobile outreach programme	Portugal	HBV, HCV, HIV/AIDS, TB	Low-threshold, outreach programme; OST	Current and former PWID; people in OST, migrants/asylum-seekers, people without housing, people who live with chronic infectious diseases	Multidisciplinary approach; peer-based; cooperation; Comprehensive programme;

Model of good practice title	Country	Infection addressed	Settings	Population	Type of intervention
					DOT
Find & Treat: Peer-led blood-borne virus community outreach project	UK	HBV, HCV, HIV/AIDS, TB	Outreach programme (homeless sites, day centres, drug treatment centres, nay congregated setting)	Current and former PWID; In particular people without housing, marginalised population	Peer-based; multidisciplinary approach; telemedicine
Hepatitis C elimination programme	UK	HCV	Low threshold; OST; prison; outreach programmes; pharmacies	Current and former PWID; people in OST, migrants/asylum-seekers, MSM, young PWID, partner contacts, prisoners, sex workers, people without housing, pregnant women	Peer-based; cooperation
Engaging the disengaged: ITTREAT, VALID and END C studies	UK	HCV	Drug treatment centres; homeless sites	Current and former PWID; in particular people without housing	Nurse lead; peer-based; integrated service; cooperation
Comprehensive care of patients with substance use disorders	Spain	HIV/AIDS	Outpatient treatment centre	Current and former PWID; people in OST, migrants/asylum-seekers, young PWID, people without housing	Multidisciplinary approach; comprehensive programme; cooperation
HepLink arm of the HepCare Europe EU-funded project	Ireland, UK, Romania, Spain	HCV	Outpatient treatment centre, OST, prison outreach programmes	Current and former PWID; people in OST	Nurse lead; integrated care
Guidelines for the screening and early diagnosis of drug-related infectious diseases	Italy	HBV, HCV, HIV/AIDS	Treatment service centres; low-threshold centres	Direct target population: Health professionals Indirect target population: current and former PWID; people in OST	Train-the-trainer

Model of good practice title	Country	Infection addressed	Settings	Population	Type of intervention
Decentralising needle exchange	Austria	HBV, HCV	Outreach programmes: homeless shelters; pharmacies	Current PWID people in OST, people without housing	NSP programme

PWID: people who inject drugs.

Annex 2. Phase 1 of Collection of Models of Good Practice. Call for expression of interest

Call for expressions of interest
Phase 1 of collection of models of good practice
Joint ECDC/EMCDDA PWID Guidance (2011) update

Fields marked with * are mandatory.

ABOUT THIS CALL

The joint ECDC & EMCDDA guidance on ***Prevention and control of infectious diseases among people who inject drugs*** **(2011)** is currently being updated. In addition to ongoing systematic reviews of peer-reviewed literature, a collection of models of good practice has been initiated by the two agencies, that should add practice-based evidence derived from interventions implemented in real-life, European settings.

We are inviting **applications to report models of good practice** targeting PWID population aiming to:

(A) improve **community-based testing**
Definition_Community-based_testing.pdf

(B) increase **linkage to care**
Definition_Linkage_to_care.pdf

(C) increase **adherence to treatment of infection interventions**
Definition_Adherence_to_treatment.pdf

(D) prevention or reduction of infections through successful **health promotion approaches**
Definition_Health_promotion_activities.pdf

The infections of interest are **hepatitis B** (HBV), **hepatitis C** (HCV), **HIV** and **tuberculosis** (TB).

Within this collection, good practice is defined as an intervention that has shown evidence of effectiveness in a particular setting and is likely to be replicable to other situations [Ng E & de Colombani P, 2015].

COLLECTING MODELS OF GOOD PRACTICE – THE PROCESS

A two-phase approach is envisaged:
Phase 1, the current phase, is the call for expressions of interest. Those who are interested in contributing to the updated ECDC, EMCDDA guidance through models of good practice are invited to answer **yes** to this survey and specify (see more details below) which topic/field will be addressed (A to D).

Phase 2, a link to a detailed reporting form (online, also hosted by EU Survey tool) will be sent to those who expressed interest. The reporting form, which was developed by Gesundheit Österreich GmbH, will facilitate and standardise this collection. It will consist of two sections: *Section 1* will collect general information on the project/programme or other type of framework under which the intervention/s has/have been implemented. *Section 2* will be specific to the field/type of intervention - (A) community-based testing; (B) linkage to care; (C) adherence to treatment of infections; (D) health promotion approaches - and will collect descriptive information on the intervention, as well as on the evidence of an impact and sustainability of the intervention. No patient level information is expected to be reported through this collection form. One model of practice may involve several interventions in which case Section 1, the general part, will remain the same and *Section 2* two will be filled-in for each type/field of intervention (A to D), as appropriate.
Models of practice that have been submitted to other databases, organisations or scientific journals and are not subject of copyright, are also welcomed under the condition the year of implementation to be no older than 2012.

NEXT STEPS - SELECTION BASED ON QUALITY CRITERIA

Models of good practice submitted through this call (after completion of phase 2) should offer detailed contextual, processual and outcome information (e.g. before/after indicators). Apart from these criteria referring to quality/completeness, the selection will aim to cover the full range of interventions (A to D) as well as the four main infections of interest. A panel of experts, to meet in February 2021, will help ECDC and EMCDAA to select from the models of good practice submitted those that will be relevant for the updated PWID guidance 2021 (either as examples in the main text of the guidance or as a repository of models of good practice).

The deadline for expression of interest **(phase 1)** is **30 September 2020** and the deadline for submission of models of good practice **(phase 2)** is **26 October 2020**.

SUBMIT YOUR EXPRESSION OF INTEREST

Should you or your organisation be interested in reporting a **model of good practice** that fits the scope of this call, please let us know by answering this survey (select the appropriate option below) by **30 September 2020**.

- **Yes, I am interested/Yes, my organization is interested.**
- **No, I am not interested/No, my organization is not interested.**

Annex 3. Phase 2 of Collection of Models of Good Practice. Reporting Form – Interventions to improve community-based testing for people who inject drugs

Available from: https://ec.europa.eu/eusurvey/runner/SFMOP2020_A

Annex 4. Phase 2 of Collection of Models of Good Practice. Reporting Form – Interventions to increase Linkage to Care for people who inject drugs

Available from: https://ec.europa.eu/eusurvey/runner/SFMOP2020_B

Annex 5. Phase 2 of Collection of Models of Good Practice. Reporting Form – Interventions to increase Adherence to Treatment of Infections among people who inject drugs

Available from: https://ec.europa.eu/eusurvey/runner/SFMOP2020_C

Annex 6. Phase 2 of Collection of Models of Good Practice. Reporting Form – Health Promotion Interventions to prevent Infections among people who inject drugs

Available from: https://ec.europa.eu/eusurvey/runner/SFMOP2020_D

Annex 7. Models of Good Practice. Assessment Form for Interventions A to C

For inclusion and core criteria a score of 1 (applicable) or 0 (not applicable) has been given. For each qualifier criteria a score has been given on a scale from 0 to 5, where 0 = not applicable and 5 = fully applicable.

(A) Interventions to improve community-based testing for PWID **(B) Interventions to increase linkage to care for PWID** **(C) Interventions to increase adherence to treatment of infections among PWID**		
PROJECT DETAILS		
Name of project		
Author		
Affiliation(s)		
Contact		
INCLUSION CRITERIA		*Indicate 1/0*
Country	Does the MoGP refer to EU/EEA member state, the UK or a country in the European Neighbouring Policy (ENP) area or the Western Balkans?	
Timeframe	Does the MoGP meets the defined timeframe (2011 until now)?	
Intervention field	Does the MoGP apply to one of the intervention areas/types (A-C)?	
Infection(s) addressed	Does the MoGP refer to one of the following infections: HCV, HBV, HIV, TB?	
PWID (sub-)population	Does the MoGP explicitly refer to PWID (sub-)populations?	
	Total score to meet criteria: min. 5 out of 5	
CORE CRITERIA		*Indicate 1/0*
Effectiveness	Is a description of the rationale/background/context provided?	
	Are effectiveness indicators clearly defined?	
	Are effectiveness indicators reported?	
	Does the intervention show an impact?	
	Is/has monitoring and evaluation of activities performed?	
	Are publications of results available? (e.g. peer-reviewed literature, grey literature, annual reports)	
	Total score to meet criteria: min. 5 out of 6	
SPECIFIER CRITERIA		*To be listed*
Setting	Is the project/programme linked to specific settings or epidemiological context?	
Target population	Is the project/programme referring to specific sub-populations of PWID?	
QUALIFIER CRITERIA		*Score 0 – 5*
Transferability[1]	Is the model transferable to other settings?	

(A) Interventions to improve community-based testing for PWID (B) Interventions to increase linkage to care for PWID (C) Interventions to increase adherence to treatment of infections among PWID		
Sustainability[2]	Is the model sustainable?	
Participation[3]	Do you consider participatory aspects as adequate?	
Inter-sectoral collaboration[4]	Do you consider involved system partners as relevant?	
	Total score to meet criteria: min. 12 out of 20	

Expert's comments
(please sum up your opinions, comments, views and state the final appraisal outcome)

[1] *Transferability - the evaluator may consider legal aspects, cost, coverage, etc;*
[2] *Sustainability - defined as funding, type of project, policy support/linkage;*
[3] *Participation - includes involvement of peers and other population groups;*
[4] *Inter-sectoral collaboration - includes the involvement of key partners and sectors within the development and/or delivery of the intervention.*

Annex 8. Models of Good Practice. Assessment Form for Intervention D

(D) Health promotion interventions to prevent infections among PWID		
PROJECT DETAILS		
Name of project		
Author		
Affiliation(s)		
Contact		
INCLUSION CRITERIA		*Indicate 1/0*
Country	Does the MoGP refer to EU/EEA member state, the UK or a country in the European Neighbouring Policy (ENP) area or the Western Balkans?	
Timeframe	Does the MoGP meets the defined timeframe (2011 until now)?	
Intervention field	Does the MoGP refer to a health promotion intervention to prevent infections among PWID?	
Infection(s) addressed	Does the MoGP refer to one of the following infections: HCV, HBV, HIV, TB?	
PWID (sub-)population	Does the MoGP explicitly refer to PWID (sub-)populations?	
	Total score to meet criteria: min. 5 out of 5	
CORE CRITERIA		*Indicate 1/0*
Effectiveness	Is a description of the rationale/background/context provided?	
	Are effectiveness indicators clearly defined?	
	Are effectiveness indicators reported?	
	Does the intervention show an impact?	
	Are the activities and materials used during implementation indicated according to main objectives and to the type of behaviour targeted?	
	Are the activities and materials used during implementation clearly described?	
	Is/has monitoring and evaluation of activities performed?	
	Are publications of results available? (e.g. peer-reviewed literature, grey literature, annual reports)	
	Total score to meet criteria: min. 6 out of 8	
SPECIFIER CRITERIA		*To be listed*
Setting	Is the project/programme linked to specific settings or epidemiological context?	
Target population	Is the project/programme referring to specific sub-populations of PWID?	
QUALIFIER CRITERIA		*Score 0 – 5*

(D) Health promotion interventions to prevent infections among PWID		
Transferability[1]	Is the model transferable to other settings?	
Sustainability[2]	Is the model sustainable?	
Participation[3]	Do you consider participatory aspects as adequate?	
Inter-sectoral collaboration[4]	Do you consider involved system partners as relevant?	
	Total score to meet criteria: min. 12 out of 20	

Expert's comments
(please sum up your opinions, comments, views and state the final appraisal outcome)

[1]Transferability - the evaluator may consider legal aspects, cost, coverage, etc;
[2]Sustainability - defined as funding, type of project, policy support/linkage;
[3]Participation - includes involvement of peers and other population groups;
[4]Inter-sectoral collaboration - includes the involvement of key partners and sectors within the development and/or delivery of the intervention.

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