

Good practice review report

Work Package 4: Support

Deliverable 4.1

Nadia Gasbarrini, Barbara Janikova, Emmi Kauppila, Jukka Koskelo,
Griet Maertens, Viktor Mravcik, Tessa Windelinckx, John Melhus



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Acronyms and Abbreviations

Ab	Anti bodies
ACF	A-Clinic Foundation
BBV	Blood born viruses
CDAP	Communicable Diseases Action Plans
CSO	Civil Society Organisation
DDAs	Direct-Acting Antivirals
ECDC	European Centre for Disease Prevention and Control
EHRA	Eurasian Harm Reduction Association
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EOT	End of Treatment
GP	General Practitioner
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
LGBTQ+	Lesbian, gay, bisexual, transgender, queer
MSM	Men having sex with men
NGO	Non-Governmental Organization
NSP	Needle and Syringe Programs
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
RNA	Ribonucleic Acid
SPR	Společnost Podané ruce
STI	Sexual transmitted infection
SVR	Sustained Virological Response
WHO	World Health Organisation

1. Introduction

Work Package 4 of the Boost project aims to scale up the implementation of people-centred good practices in HIV/HBV/HCV services for people who use drugs among community-based organizations with a focus on integrated interventions, expansion of community voluntary testing, and linkage to treatment options. Within the work package, the aims are to develop four organizations into centres of expertise to function as “Lighthouses” within their region through the build-up of a peer network among them, support selected interested Harm Reduction community-based organizations to implement effective Communicable Diseases Action Plans (CDAPs) that fit the local context.

A peer-consultation mechanism among four organizations (lighthouses) was established to enhance knowledge and competence transfer among them by creating a mutual learning exchange platform, organizing cross-topical meetings on key common issues and concerns.

This report summarizes approaches of lighthouse partners, reviewing recently published best practice collections in infection prevention and control, and documenting community-led responses to communicable diseases and drawing out lessons for the development of good practice among community-led organizations. Finally, the report brings together and reviews good practices, barriers, and legal frameworks.

2. Approaches of Lighthouse Partners

2.1. Belgium - Antwerp - NGO Free Clinic

The Antwerp Model: an integrated multidisciplinary model of care with strong peer-support to ensure continuum of HCV care for People Who Use Drugs.

Background

Hepatitis C treatment has improved substantially over the last few years, leading to highly successful, shorter regimens that are better tolerated by patients with minor side-effects. In addition to these significant changes, people with a history of injecting drug use can be treated as easily as any other person living with hepatitis C. Yet, there is a need to improve linkage to care for hepatitis C for this population group.

Regarding this scenario, Free Clinic NGO, a harm reduction service provider based in Antwerp, started an intensive collaboration with Ziekenhuis Netwerk Antwerpen (local hospital) to apply a comprehensive approach for hepatitis C case management for people who use drugs – dubbed The Antwerp Model, assisted by the peer-support programme of the C-Buddies project.

Description of the good practice

The Antwerp Model aims to enhance hepatitis C testing, linkage to care, and treatment uptake through: (1) screening with HCV Ab RDTs and off-site confirmatory tests for viraemic infection, (2) integrated hepatitis C care delivered by professionals in a low-threshold harm reduction setting, (3) community-based, nurse-led evaluation, information, education, and counselling (IEC), (4) timely referral to hepatitis specialists when needed, (5) non-invasive assessment of liver fibrosis with transient elastography, and (6) continuous peer support for information, education, and counselling, scheduling appointments, follow-up of special situations, tracing of patients referred to other services, home visits, and patient navigation at the hospital.

The Antwerp Model abides by four main pillars: (1) NGO Free Clinic (founded in 1972) to provide pre-test counselling, testing, information, education and counselling, referral, comprehensive follow-up, and opportunity to talk about safer drug use, (2) established Needle and Syringe Programmes (founded in 2001) for distribution of injection equipment and referral, (3) local hospital specialists to assist with additional testing, staging, referral, treatment, and follow-up, (4) C-Buddies project (founded in 2009) to provide peer support throughout the continuum of care. The model of care is highly flexible and can be quickly adapted to the needs of users and partners. The teams are trained to be street-wise in their actions.

C-Buddies project peers establish first contact with people who use drugs in hotspots, homeless shelters, and other low-threshold facilities. They can deliver hepatitis C screening on-site and on demand, assist people to come to appointments, and remind them by using text messages.

All people who use drugs and come to appointments with the hepatology specialist are welcomed at the entrance of the hospital and assisted in navigation by a peer. In the case of absentees and outstanding situations, both the hepatology specialist and peer always work together to devise creative

solutions, considering social determinants of health and the fact that people may not be ready for abstinence from alcohol and drugs.

Evidence of impact

Within the WHO best practice document, the data from 2017 were described. In 2017, approximately 90% of People Who Use Drugs assisted by this model were successfully screened for hepatitis C, with diagnosis being confirmed in 105 out of 245 of them (Figure 1). In 2018, approximately 130 PWUD benefited from these testing activities. The reimbursement of hepatitis C treatment with DAAs for those with social security numbers was implemented in 2019, and improvements in treatment uptake are expected in the near future.

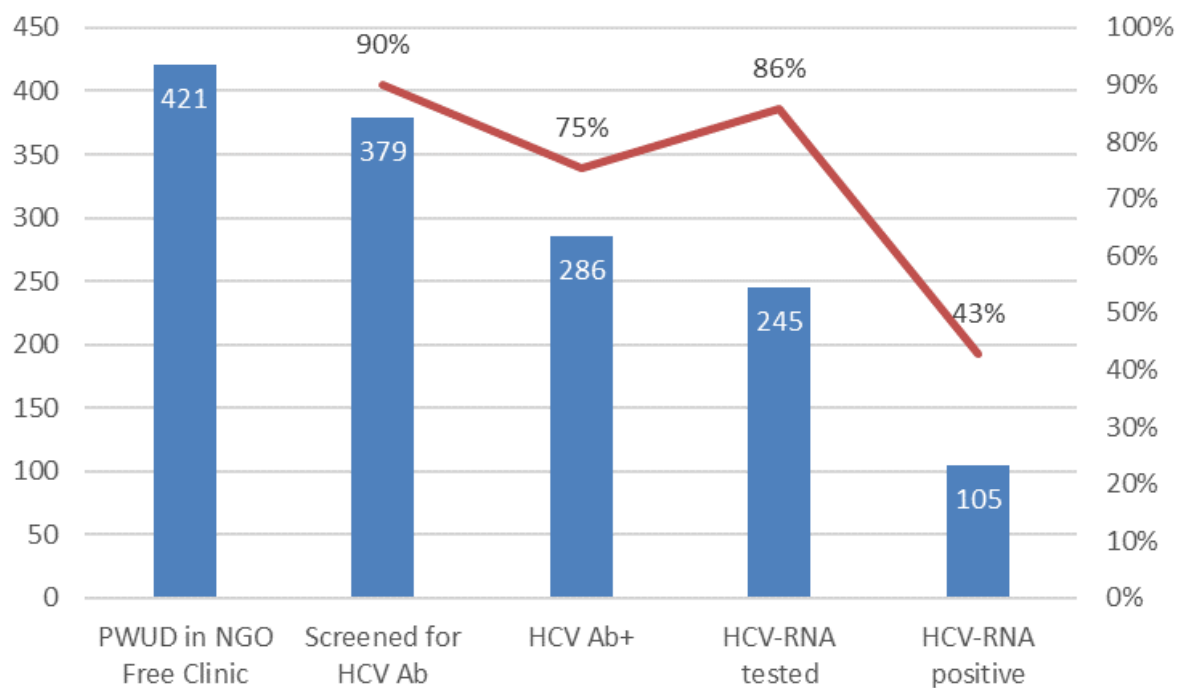


Figure 1: Cascade of care for PWUD in NGO Free Clinic, tested for hepatitis C and supported by peers from C-Buddies project, Antwerp, Belgium, 2017.

Thanks to the Antwerp model and the C-Buddies system, the most vulnerable population group have improved access to hepatitis C diagnosis and continuum of care.

In 2022, 153 people were in follow-up by the C-Buddy project, 111 people were RNA positive in present or past, 107 among them were treated in the past or in 2022 (see Figure 2).

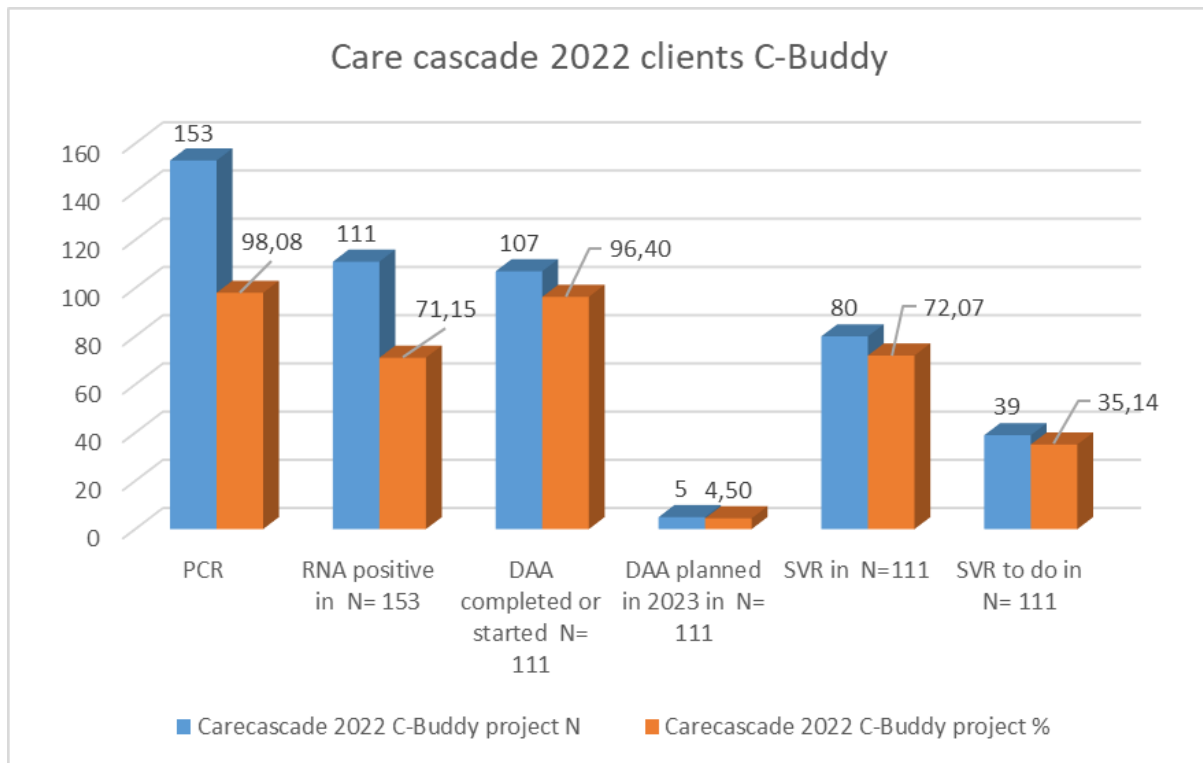


Figure 2: Care cascade 2022

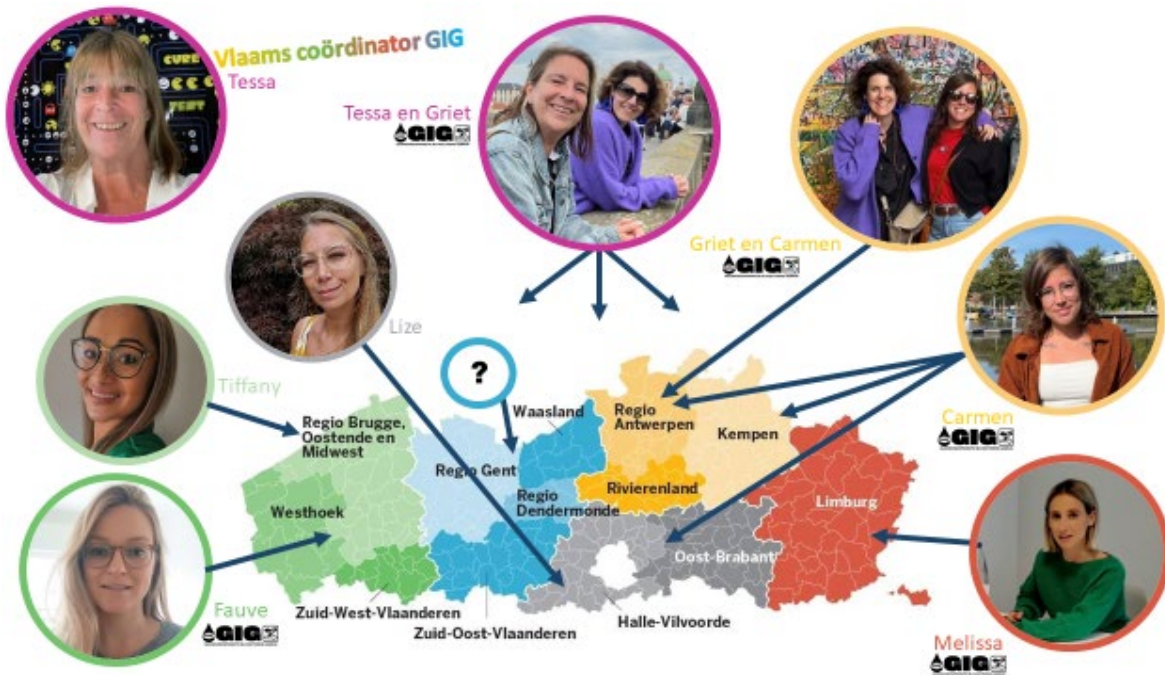
Sustainability

[Free Clinic](#) and C-Buddies receive funds from the Flemish government through “Health Promotion in Injecting Drug Use” (Gezondheidspromotie bij Injecterend Gebruik) with activities structurally sound with funding until 2025. C-Buddies activities have been recognized at the Flemish Parliament. An expansion of the services in the Flemish region is planned for the future, with a pilot project already conducted in Sint Niklaas in 2018. The team contacted treatment and care services, reached out to people who use drugs, provided RDTs and referral to local hepatology specialist and even initiated some treatments. Another initiative since 2022 is the creation of ExpertC centres in every Flemish region to support local initiatives, development of cascades of care and improve strategic information, and the overall continuum of care. The project was also described in several documents¹.

¹ <https://www.euro.who.int/en/health-topics/communicable-diseases/hepatitis/publications/2020/compendium-of-good-practices-in-the-health-sector-response-to-viral-hepatitis-in-the-who-european-region-2020>
<https://www.emcdda.europa.eu/drugs-library/hepatitis-c-new-models-care-drugs-services>



Picture 1: C-Buddy team, the Antwerp Model, ngo Free Clinic



Picture 2: GIG team, Flanders Belgium, ngo Free Clinic

TEST-----TREAT-----CURE
 WHY CASEMANAGEMENT IS NOT SUFFICIENT ANYMORE
 PWUDS WITH MULTI PROBLEMS NEED CAREMANAGEMENT

PWUID HEP C CAREMANAGEMENT

N=150

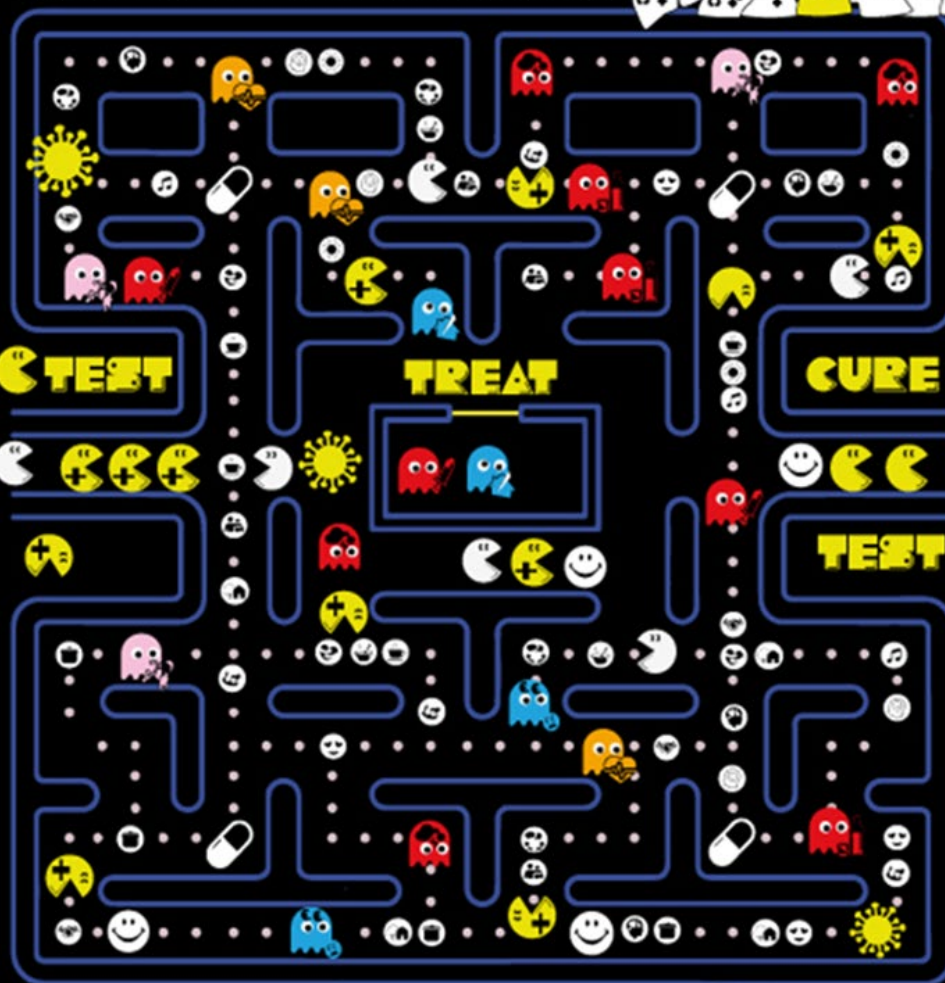
Need high level of support-----	62,4%
No social network-----	48,4%
Alcohol abuse-----	63,8%
IV druguse during treatment-----	53,8%
Mental health issues-----	48,5%
Poor general health-----	45,8%
Fysical co-morbidity-----	71,4%
No income-----	13,7%
Social benefits income-----	76,3%
No permanent housing-----	32,1%
Living in homeless shelters-----	85,8%

'The Antwerp model'
 is a close cooperation between FREE CLINIC ngo (low-threshold service for PWUD, from HARM REDUCTION perspective) and ZNA COMMUNITY HOSPITAL, in order to OFFER HCV CARE to EVERY PWUD.

In the early days of interferon we have treated the most motivated, during the first years of DAA we treated the most sick (F3,F4) and later on the easiest to catch. Since a few years we've noticed we are left with a group of PWUD that are difficult to link to the care cascade since they face multiple problems on multiple levels.

conclusion...
PWUDS WITH MULTI PROBLEMS NEED GLOBAL MEDICAL AND NON-MEDICAL SUPPORT...

BASED ON A TRUE AND COMPLEX STORY



.....INCLUDING
 OUTREACH
 AND
 A STRONG
 PEER SUPPORT
 PROGRAM



WE SUPPORT
 LIFE GOES ON



PREVENTION
 OF
 REINFECTION

Authors:
 Windelinckx T
 (Healthcare worker in injecting drug use)
 Bourgeois S
 (Researcher ZNA - Hospital)
 Bostvanden S
 (Dr. Kayser W)
 Weynants S
 (Healthcare worker in injecting drug use)
 Torfs-Isbenen C
 Maertens G
 (HCV reference nurse
 coordinator C-Care project, ago Free Clinic)

Picture 3: Poster presentation at INHSU 2022, Glasgow. Windelinckx T et al

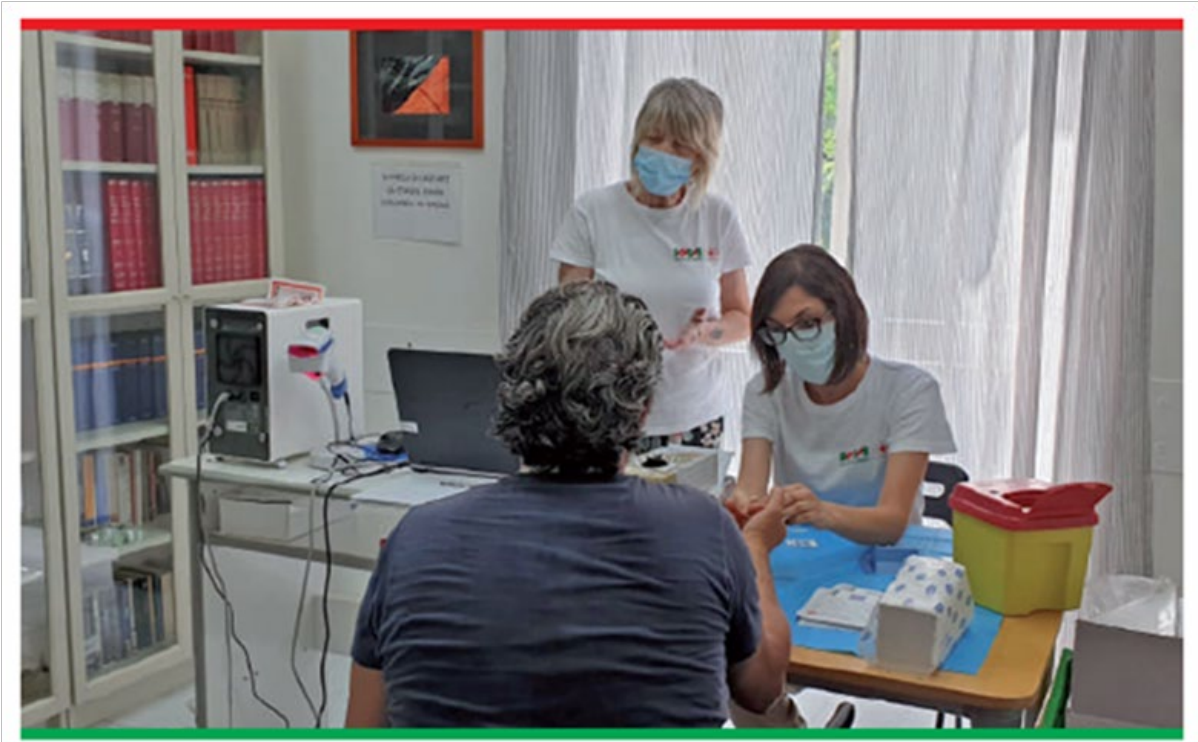
2.2. Italy - Rome - Villa Maraini Foundation

A model of integrated and combined provision of interventions for treatment and care of PWUD

[Villa Maraini Foundation](#) is a drug treatment centre based in Rome, Italy. Founded by Dr. Massimo Barra in 1976, it offers a wide range of services and programmes for People Who Use Drugs/People Who Inject Drugs and other vulnerable groups (sex workers, LGBT+, migrants, homeless), with the objective to provide multi-disciplinary therapeutic interventions adapted to the different needs and situations of the clients. The services are articulated on different threshold levels: low, medium, and high, depending on the motivation of the person toward treatment, but they are all linked and interconnected, as part of an integrated and comprehensive system of care. The low-threshold services include the street unit, emergency unit, daily drop-in centre, night shelter, and prison project. The high-threshold services consist of semi-residential, residential, and outpatient treatment programmes. Regarding the medical services, Villa Maraini has a medical centre for the delivery of pharmacological therapies (methadone and others) and an infectious diseases unit for HIV/HCV/STIs prevention, treatment, and care. These services are open 24 hours every day, including Sundays and holidays.

To this end, for many years Villa Maraini has been implementing the campaign “Meet, Test & Treat”, aimed at raising awareness and promoting access to testing for HIV and HCV among most-at-risk groups such as People Who Inject Drugs, sex workers, MSM, and LGBT+ communities, migrants. The campaign is carried out through the mobile street unit, reaching different places in the city of Rome to offer free-of-charge counselling and testing for HIV and HCV, as well as informative materials about the two infections.

The testing is provided both on the street through the mobile Street Unit and onsite in the medical centre. In case of preliminary positive results to rapid tests for HIV and/or HCV, the person receives informative and supportive counselling and is immediately referred and linked to clinical centres for confirmatory testing and treatment. Access to diagnosis and treatment is ensured by the “fast track” referral system established with an infectious diseases hospital in Rome. The Villa Maraini staff takes care of contacting the hospital and scheduling an appointment for the confirmatory testing. A transport and accompanying service to the health facility is provided for people with high social marginality who are unable to reach the clinical centre independently. In the case of migrants without the necessary documentation to access the public health service, an accompanying service is offered at the relevant public offices for obtaining the necessary documents for access to care and treatment. Follow-up monitoring, adherence to treatment, and post-treatment evaluation are regularly conducted by the medical staff of Villa Maraini through individual counselling and medical check-ups, as well as through the exchange of information with the infectious diseases centres providing treatment and care.



Picture 4: Rapid Testing in Villa Maraini medical centre



Picture 5: Rapid Testing in outreach settings

**STIGMA KILLS
MORE
THAN DRUGS**



FONDAZIONE VILLA MARAINI



Croce Rossa Italiana

WWW.VILLAMARAINI.IT

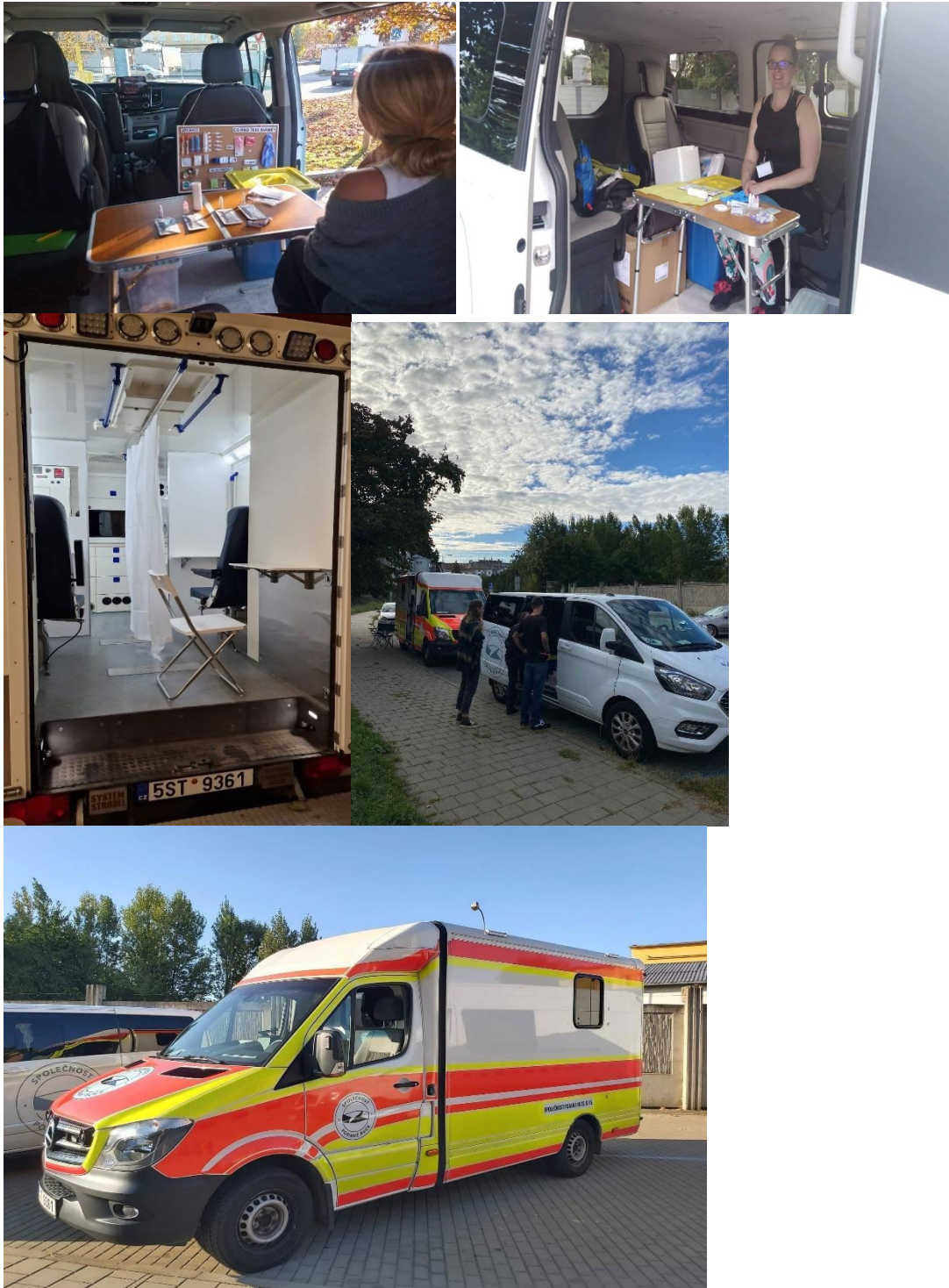
Picture 6: Anti-stigma campaign

2.3. Czech Republic - Brno - Společnost Podané ruce

Integrated multidisciplinary model of comprehensive care and peer support

[Společnost Podané ruce \(SPR\)](#) is a non-profit, non-governmental organisation founded in 1991 in the second-largest city, Brno, just after the fall of the communist regime. It is one of the leading organisations in the country in harm reduction, prevention, treatment, and care, as well as in national drug policy development. It provides a network of complex services that range from harm reduction services such as outreach/mobile programs and drop-in centres to community-based services, outpatient/inpatient treatment programs (therapeutic community), supported housing, and special services for young people, families, tutors, schools, and people who use drugs serving sentences in prisons. To deliver services, SPR counts on a team of 250 staff spread across the country to run services in some 50 centres. SPR also impacts at the national level by leading the Association of Non-governmental Organisations, which brings together some 26 key organisations involved in the addiction field in the Czech Republic.

Confidential voluntary testing for HIV, HCV, in some sites HBV, and sexually transmitted infections (syphilis) and linkage to care are mainly provided in harm reduction services (20 programs in 3 regions) such as drop-in centres, outreach programs, and mobile units, with more than 2000 rapid tests per year. The finger prick and saliva tests are used, and in some programs, venipuncture as well. The client is offered a test and, if needed, assistance to the specialist. The entire spectrum of clients' needs is taken into account, and help is offered (housing, documents, relationships, information, peer support). The medical doctor – infection-diseases specialist – from the Podané ruce Clinic provides medical care and treatment to the referred clients. In 2023, the Clinic became the 26th DAA centre in the Czech Republic, thus making the linkage to care very convenient for the drug services clients. The HCV nurse from the Clinic also offers venipuncture in the outreach services (mobile unit) and drop-in centres in Brno. Peers from the StreetSupport Peer Group are involved in the continuum of care, mainly in linkage to care and treatment, and post-treatment support. Clients are supported throughout the process of diagnostics and care on a case management basis. Motivation is supported by incentives.



Picture 7: Outreach program in Brno, Czech Republic – mobile unit and mobile drug consumption room. Photo: Společnost Podané ruce

2.4. Finland – Helsinki – A-Clinic Foundation

The [A-Clinic Foundation](#) (ACF), founded in 1955, is a non-profit and non-governmental organisation in Finland. It works to prevent and reduce substance use, mental health issues, and other social and health-related challenges, while also supporting the inclusion of vulnerable individuals.

ACF is dedicated to improving the status of individuals suffering from substance use issues, as well as their loved ones. The foundation has 80 employees who engage in face-to-face interactions in peer groups, low-threshold meeting points, and street outreach. Its online services attract nearly four million visitors annually.

ACF owns [A-Clinic Ltd](#) which provides expert services in reducing substance use and other psychosocial problems, offering treatment and rehabilitation services. A-Clinic Ltd employs 500 people.

In total, the A-Clinic Foundation manages seven different projects focusing on harm reduction. Of these, five (Katuklinikka, Osis, Völjy, Tykö, Vapariväylä) offer face-to-face services and reach approximately 2,000 people annually. Additionally, there is an online service (Dopinglinkki), which attracts about 30,000 visitors monthly.

ACF's harm reduction efforts include HCV/HIV testing, social services, a needle and syringe programme, housing support, and survival-oriented services for the homeless. Notably, its harm reduction work, especially in HCV and HIV testing, is not limited to People Who Use Drugs (PWUD) but also extends to those who inject performance- and image-enhancing drugs for recreational purposes, a practice that is uncommon in the EU. Lastly, ACF provides support, advice, education, and research on an international scale and is a member of several European networks and advisory boards.

Picture 8: HCV testing in Finland. Photo: A-Clinic Foundation.



2.5. Summary of the Lighthouse Approaches

Differences have been recognised between lighthouses. For example, Belgium's model is making testing and care easier for people who inject drugs (PWID), achieving a 90% success rate in 2017, and the organization has secured funding until 2025. Italy's Villa Maraini Foundation, established in 1976, offers integrated approaches and runs the impactful "Meet, Test & Treat" campaign. In the Czech Republic, Společnost Podané ruce (SPR) offers testing and linkage to care in more than 20 addiction services across three regions of the country and is also helping to shape the country's drug policy. Finland's A-Clinic Foundation works with a number of projects that reach people both online and in person.

These changes are making the care for Hepatitis C and other infections, as well as harm reduction, more flexible and community-focused across Europe. One of the most important functions of lighthouses is to support each other and improve outcomes for everyone..

3. Review of the best practice collections in infection prevention and control

3.1. Introduction

After a comprehensive review and analysis of multiple documents focused on increasing access to hepatitis C and other infections testing and care for people who use drugs, with special attention to people who inject drugs (PWID), several key conclusions can be drawn. The documents, ranging from manuals to guidelines and good practice examples, provide insights into various aspects of harm reduction services, addiction services, healthcare settings, and preventive efforts.

In summary, reviewing ten recent hepatitis C and other infection guidelines, the most consistently emphasised areas include widespread screening and consistent linkage to care, reflecting their central importance in disease management and prevention. Conversely, areas such as post-treatment care, stigma reduction, community outreach, and the utilisation of mobile healthcare services and HCV nurses are identified as critical but less frequently mentioned, indicating key opportunities for strengthening the hepatitis C care continuum.

3.2. Methodology

Ten recent documents and guidelines on hepatitis C and other infections were included in this review. Each document was thoroughly read, and 18 different categories and/or variables were collected if they were mentioned in these documents. The categories included awareness and prevention, motivation for screening, HCV/HIV/TB screening, linkage to care, DAA treatment, EOT (End of Treatment), SVR (Sustained Virological Response), follow-up, other medical issues, stigmatisation, engagement of people who use drugs, case management, vulnerable/most affected population groups (e.g., PWID, prisoners), training of key workers, incentives for clients, partnerships between harm reduction facilities and medical centres, training of clients, and the use of a shared database. The collected data were analysed and summarised.

3.3. Documents reviewed

1. [European Monitoring Centre for Drugs and Drug Addiction \(2021\). Increasing access to hepatitis C testing and care for people who inject drugs Identifying barriers to and opportunities for supporting hepatitis C testing and care in drug services: a participatory diagnostic process](#)

This document underscores the urgent need for improved access to HCV testing and treatment, particularly highlighting the high prevalence of the disease among people who use drugs. It recommends adopting a participatory diagnostic process to identify and overcome barriers to HCV care, involving a diverse range of stakeholders from system, provider, and client levels. Key steps include assessing the need for HCV testing in drug services, conducting consultations with multiple stakeholders to identify barriers and solutions, and ensuring effective monitoring and evaluation of the strategies implemented. This guide is intended to support healthcare providers and policymakers in enhancing HCV prevention and treatment services, with a focus on addressing the needs of vulnerable populations.

2. [Schatz, E., Perez Gayo, R., & Raulet, I. \(2019\). Hepatitis C interventions by organizations providing Harm reduction services in Europe – analysis and examples](#)

The document explores harm reduction interventions across Europe, specifically focusing on hepatitis C. It highlights the importance of interventions such as regular testing, awareness campaigns, and accessible healthcare services. The report provides a comprehensive overview of effective practices in harm reduction settings by showcasing examples of 14 different programs in Europe, serving as a crucial resource for understanding the various strategies employed in HCV management. This analysis is particularly beneficial for those seeking to grasp the scope and effectiveness of harm reduction interventions in the context of Hepatitis C across various European settings.

3. [Eurasian Harm Reduction Association. Components, Arguments, Criteria of Quality Harm Reduction Services.](#)

This document offers a comprehensive framework for assessing and improving the quality of harm reduction services for people who use drugs. It emphasizes the importance of respecting individuals' dignity, responding to client needs, and involving people who use drugs in service planning. The report underscores the significance of addressing diverse needs, encompassing health, social, and legal aspects, and outlines criteria for implementing high-quality services. This tool is intended to guide harm reduction practitioners in ensuring their services are effective, inclusive, and respectful.

4. [WHO. \(2018\). Guidelines for the care and treatment of persons diagnosed with chronic hepatitis C virus infection.](#)

These guidelines offer evidence-based recommendations for the care and treatment of individuals diagnosed with chronic HCV infection. They update the care and treatment section of the WHO Guidelines for the screening, care, and treatment of persons with hepatitis C infection issued in

2016. The focus is on eliminating Hepatitis C as a public health threat by 2030, advocating for widespread diagnosis and treatment. These guidelines are intended to be used by stakeholders as a basis for developing national hepatitis policies, plans, and treatment guidelines. They are particularly aimed at country programme managers and healthcare providers responsible for planning and implementing hepatitis care and treatment programmes.

5. [European Monitoring Centre for Drugs and Drug Addiction \(2023\). Drug-related infectious diseases: health and social responses. Miniguide.](#)

This miniguide on responding to drug-related infectious diseases is part of a larger set, which together comprise 'Health and social responses to drug problems: a European guide', developed by EMCDDA. It provides an overview of the most important aspects to consider when planning or delivering health and social responses to drug-related infectious diseases. It reviews the availability and effectiveness of these responses, as well as considering implications for policy and practice.

Implications for policy and practice: Basic core interventions in this area include needle and syringe programmes, opioid agonist treatment, testing and treatment for infectious diseases, and health promotion activities.

Opportunities: Implementing an integrated strategy that provides prevention, outreach, screening, and hepatitis C treatments in coordination with harm reduction (including needle and syringe programmes) and drug treatment programmes (including opioid agonist treatment) in both community and prison settings could reduce liver disease and cancers, and potentially eliminate hepatitis C as a public health threat among people who inject drugs.

Gaps: Outbreaks linked to stimulant use continue to be documented and represent a serious threat to public health. Enhanced early detection, real-time surveillance, and greater collaboration between national and regional agencies are important goals in this area. Access to needle and syringe programmes and opioid agonist treatment is currently below recommended levels in many EU countries and needs improvement.

The provision of responses to prevent and treat drug-related diseases remains low in some high-risk settings, such as prisons and other custodial facilities.

6. [ECDC \(2022\). 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.](#)

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 a cross-national project carried out in Ireland, Romania, Spain, and the UK. Most of these projects addressed hepatitis C (10 projects), as well as HIV (7 projects), with HBV covered in four projects and TB in three projects. Nearly all projects addressed more than one infection, with those focusing solely on one infection targeting the HCV care cascade exclusively.

Among the 12 projects/programmes from which the models of practice emerged, seven integrated a peer involvement approach. This approach was used to enhance community-based testing (e.g., outreach peer support, peer-to-peer recruiting, involvement in point-of-care testing), increase linkage to care (e.g., peer navigators supporting referrals, outreach tracing of those not in care), and increase adherence to treatment (e.g., maintaining regular contact during treatment). Another frequently used approach (in 5 out of 12 projects) was the integration of nurses into the treatment cascade. In addition, more than half of the projects employed a multidisciplinary approach and focused on cooperation between drug services and specialised healthcare services, often using a low-threshold approach, particularly to increase linkage to care. A synopsis of the 12 models of practice by type of intervention, settings, and people who inject drugs subpopulations is presented in the document.

7. [EMCDDA \(2019\). Hepatitis C: new models of care for drugs services.](#)

Hepatitis C virus (HCV) infection has a high prevalence among people who inject drugs (PWID) in Europe, despite being both preventable and curable. There is a need for effective interventions targeting the prevention of HCV transmission and the treatment of hepatitis C, particularly for so-called 'hard to reach' and vulnerable populations. European clinical guidelines recommend that all patients with chronic liver disease as a result of HCV infection should be considered for therapy, regardless of the disease stage. Furthermore, they advocate providing treatment to individuals at risk of transmitting the disease, including those currently injecting drugs. The beneficial impact of hepatitis C treatment on the infected individual and its indirect impact on reducing onward transmission in the community make 'testing and linkage to treatment' a core component of the hepatitis C elimination strategy. The importance of targeting People Who Inject Drugs as a key population for the elimination of hepatitis C in Europe, and of promoting people's access to testing and all other elements of the cascade of care, is highlighted in European and national hepatitis C policies. The 11 case studies in this collection document how drug treatment and harm reduction service providers in eight countries are supporting people's access to testing and treatment, using innovative and creative implementation practices and developing new models of care for this important target group. This publication provides key insights into the results, impact, sustainability, and transferability of each practice to guide the implementation of these new models of care in other countries and settings.

8. [WHO \(2020\). Compendium of good practices in the health sector response to viral hepatitis in the WHO European Region.](#)

In line with the implementation of the Action Plan for the Health Sector Response to Viral Hepatitis in the WHO European Region, the WHO Regional Office for Europe launched an official call for good practices on viral hepatitis in May 2019. National health authorities, intraregional programmes, national technical focal points and programmes, civil society organizations (CSOs), and non-governmental organizations (NGOs) responding to viral hepatitis were invited to submit exemplary practices. The narratives were collected over six months, from May to November 2019, compiled, and evaluated against pre-defined criteria, and were technically reviewed by WHO experts in the Regional Office. This compendium includes 34 practice examples from 18 Member States in the WHO European Region, authored by various actors in the collective response to viral hepatitis. These actors include government and national viral hepatitis programmes, academia, public health/research institutes, and NGOs and CSOs.

9. [ECDC and EMCDDA \(2023\). Prevention and control of infectious diseases among people who inject drugs: 2023 update](#)

This guidance is a 2011 update that accounts for advances in harm reduction and infectious diseases prevention and control, the emergence of new public health concepts and interventions, and stakeholder needs. While the main intervention areas are replicated, the areas of health promotion and targeted delivery of services have been updated and incorporated into the section on ‘Principles for prevention and service provision’. This includes: delivering interventions in combination with health promotion activities that address both structural and behavioural factors, and in combination with each other; adopting a practical, targeted, community-based, and person-centred approach to service provision; adopting a client's rights perspective, including refraining from ideological and moral judgment and ensuring confidentiality; ensuring services are well-organized and of high quality, including the level of training of staff; promoting service accessibility, uptake, and coverage through combined provision of interventions; informing service provision through evidence-based guidance; and monitoring and evaluating.

Health promotion was broadened to also address structural and individual factors that contribute to enabling environments that promote healthier and/or safer behaviours. At the structural level, WHO recommends removing punitive laws, policies, and practices, such as the criminalisation of possession of needles and syringes; reducing stigma and discrimination; promoting community empowerment; and addressing violence against people who inject drugs. Addressing stigma and ensuring meaningful engagement of people who inject drugs in how services are provided is also necessary to ensure the acceptability and relevance of services for this population. At the individual level, health promotion activities should focus on moving towards safer injecting behaviour and reduced injection frequency, transitioning to non-injecting drug use, cessation of drug use if desired, and safer sexual behaviour, as well as increasing knowledge of infectious diseases prevention, testing, and treatment.

Guidance updates in the other intervention areas are as follows:

- Provision of sterile injecting equipment: Recommendations are based on an updated evidence review conducted in 2020, which also includes a review of the effects of low dead space syringes (LDSS) in preventing the transmission of HCV and HIV.
- Drug dependence treatment: Recommendations are based on an updated evidence review conducted in 2020. This review covers medical (including pharmacological), psychological, social, and behavioural approaches to address problems associated with drug dependence. These include agonist treatment for opioid dependence, pharmacological treatment for stimulant dependence, psychosocial interventions involving information, education, counselling, and/or skills training (IECS), psychosocial interventions involving contingency management, and technology-based psychosocial interventions in the community and in prisons.
- Vaccination: COVID-19 vaccination is addressed, and recommendations for human papillomavirus (HPV) vaccination have been included.
- Drug consumption rooms providing supervised injecting facilities: Drug consumption rooms are now included as a distinct intervention area, and the topic was included in the updated evidence review.

10. EuroNPUD European Network of People who Use Drugs: Community-Led Approaches to Technical Briefing HCV Testing, Treatment and Care - Technical Briefing (2023) Document: [TB_HCV.pdf](#)

The key argument for community-led approaches to hepatitis (HCV) testing, treatment and care is that they are highly effective in increasing HCV testing and treatment uptake and retention rates among people who use drugs due to their unique advantage in providing privileged access. This access is a crucial pathway, allowing for multiple points of entry essential for reaching both the treatment and non-treatment populations.

As highlighted in the case studies included in this Technical Briefing, the impact of peer workers and drug user activists on the expansion of HCV testing, treatment and care is substantial. Their dedication aligns seamlessly with the strategic objective of saturating peer networks with essential resources and knowledge, thereby facilitating broad access to comprehensive HCV testing, treatment and care.

This briefing includes two case studies that spotlight successful community-led approaches in Portugal and Norway, offering valuable insights into the effectiveness of integrating peer-led initiatives into HCV healthcare strategies

The two case studies in Norway and Portugal provide two different types of venues where HCV testing is provided: The ProLar Hepatitis Bus in Norway involves a peer lead mobile testing unit that travels to different locations, including institutions and shelters, allowing service to reach diverse populations, especially those who may fear and avoid conventional healthcare. Service users appreciate the peer-driven approach, fostering trust in the testing process and providing a preferred alternative to traditional hospitals. Health personnel commend the initiative especially for its time and cost-effectiveness, saving them from multiple hospital drives and allowing them to focus on comprehensive care. The mobile testing van provides a direct screening test, then a diagnostic test, an ultrasound of the liver and within hours, provides a prompt prescription of necessary medication available for the service user at the service provider the next day.

Portugal's IN-Mouraria relies on a fixed drop-in centre in Lisbon providing a consistent location for services, providing tailored services to meet the needs of People who use drugs. Unlike conventional clinical settings, GAT Mouraria's flexible schedule, adapted to the needs of the community, ensures better attendance and engagement. Peer workers at GAT play a vital role in supporting clients through the process. They help book appointments, provide emotional support, and facilitate communication between clients and medical professionals.

Both models show that peer workers' shared experiences and understanding of drug use create a sense of trust and empathy, making it easier for clients to access care. Both also provide low threshold peer to peer NSP with sterile injecting equipment and other harm reduction necessities to prevent HIV and Hepatitis C transmission

3.4. Lessons learned by Lighthouses

Hereby we summarise the experience of the Lighthouses organizations in reviewing the guidelines and best practices reports. What could be improved based on the review?

1. Villa Maraini, Italy

The good practices review underscores the feasibility and effectiveness of engaging HCV-specialised nurses for screening and testing, as well as for linkage to care. This information is particularly relevant for us, as we currently do not have nurses in our programmes, but are considering the opportunity to involve them. Having such positive examples of the role nurses can play in HIV/HCV programmes serves as a motivation to introduce such professional staff into our team.

Another important aspect of this collection of good practices is the collaboration with pharmacies. Villa Maraini is currently implementing a pilot project involving pharmacies located in the city of Rome for the delivery of free-of-charge HIV and HCV rapid testing and information about these infections. This review of good practices reveals that this can be a significant area for improvement. The use of pharmacies for the provision of information and screening is still underused and underestimated, yet it has enormous potential for expanding HIV/HCV healthcare coverage.

2. NGO Free Clinic, Belgium

The good practice review reinforces our approach within the Antwerp model, which involves strong cooperation between HCV nurses, peers, needle exchanges, and local liver specialists, focusing on CARE management. This approach is holistic, addressing not only the infection but also broader health aspects.

Our project's funding is primarily for hepatitis C screening and linkage to care. While we screen and refer for other infectious diseases when indicated, good practice suggests we need to structurally broaden our focus to include more infectious diseases than we currently do. To upscale this, more funding, time, and personnel are required.

In Belgium, there is still a need for diagnostics RNA with blood samples. However, different countries accept RNA testing with the Cepheid machine. Validating this method would simplify access to care in HCV and enhance treatment uptake. Mobile screening can be improved – currently, we screen at fixed locations like shelters and Needle Syringe Programs (NSP). A pilot for screening at hotspots on the street should be part of our future planning and adapt to the local context. There's also a need to upscale, improve, and simplify data collection (using a uniform data collection tool nationwide). Additionally, we should consider working with incentives - involving peers who connect others for screening and treatment.

Screening and treatment should be expanded to include people in prison or in residential (psychiatric) care. Our project must take action and advocate for working in prisons and psychiatric units, at least in linking people to care when they leave these settings.

In tackling the spread of infectious diseases, drug consumption rooms are one of the key factors, which are currently lacking in the Flemish part of Belgium.

3. Společnost Podané ruce, Czech Republic

A quality system of testing and linkage to care has been developed, which could be further upscaled and broadened if additional resources are available. Nationally, there is a legal challenge, as finger prick blood collection can only be performed by a healthcare worker. This legal stipulation presents a barrier to scaling up testing for some services. Additionally, there is a lack of HCV-specialized healthcare personnel, particularly nurses, who are willing to work in addiction services with people

who use drugs. DAAs are only available in specialized centres, which poses barriers for clients, including travel distance, financial constraints, and time issues. There is no national monitoring of the cascade of care through a structured approach across services. A screening pilot project is currently being undertaken with the aim of screening and treating people who use drugs. This project involves testing in low-threshold settings and following up the client's care in a shared database with HCV DAA treatment centres.

For the lighthouse, there is room to strengthen peer involvement in the work, particularly in outreach and support for anti-HCV+ clients. Monitoring and data collection is an area that requires further development; currently, data availability is limited. As the incentives are provided on a project basis, there could be financial constraints in motivating service clients for testing and treatment, and in involving peers in the continuum of care, should the project end.

4. A-Clinic Foundation, Finland

The collection of these documents highlighted the importance of best practice collections, particularly in developing and improving our services for PWUD. Since our foundation is not the only organisation in Finland providing services for PWUD, the significance of collaboration between different actors was clearly demonstrated in these documents. All guidelines, especially the most recent ones and their updates, should not be viewed merely as interesting reading material. Instead, their content should be actively implemented into practice, and the process of implementation, as well as its outcomes, should be thoroughly documented and measured. This approach will be one of the key areas that our foundation aims to implement in practice in the near future.

There has been considerable public and governmental discussion about drug consumption rooms in Finland over the past few years. Information, guidelines, research, and best practices from other countries will not only improve our services but also clarify what kind of services should be considered by our foundation and in our country. The idea of incorporating a mobile van is worth considering as one of our services in the future.

This collection of models of good practice describes interventions and approaches currently being successfully used by European countries to address the care cascade of infections among people who use or inject drugs. The submitted models of good practice indicate a scarcity of high-quality data for measuring practice-based evidence. It also highlights the extensive amount of preparatory and supporting work (e.g., preparedness of the care environment and clients) required to quantify the effectiveness of interventions. This is particularly relevant in hard-to-reach populations, such as people who inject drugs.

The models of good practice presented here underscore the need for programmes to be flexible and adaptable. They should tailor their approaches to national legal frameworks, existing healthcare and drug services, and the specific needs of the target populations of people who inject drugs. Factors such as peer involvement, trust, and convenience to patients, along with community or low-threshold approaches that cover a broad spectrum of patient needs, are identified as successful strategies. Systematically assessing the effects of such interventions deserves more focus in future research agendas.

4. Summary of main areas mentioned in the best practice collections

Awareness and prevention

These documents collectively highlight the importance of awareness and prevention strategies. There is a consensus on the need for harm reduction services to collaborate with addiction services, general practitioners, and healthcare services to effectively reach the target population.

The emphasis on preventive work is evident, with acknowledgment of the role of peers and volunteers in creating awareness.

Motivation to screening

As the most frequently mentioned service, screening is evidently considered a critical component of hepatitis C and other infectious disease intervention strategies. Motivating individuals for screening is identified as a crucial step in the intervention process. All documents recognize the importance of collaborative efforts between harm reduction services, addiction services, and healthcare providers in motivating individuals for screening. The involvement of peers and volunteers is crucial in this stage to establish trust and rapport, but also reducing stigma. The guidelines underscore the need for its widespread implementation, especially targeting high-risk populations.

Screening and diagnostic tests

The evaluation of screening practices and diagnostic tests reveals a consensus on the significance of efficient and accessible screening methods. Documents emphasise the need for mobile vans, outreach programs, and harm reduction services to facilitate screenings. The assessment of antibody (ab) and RNA testing is consistent across the documents, emphasising the importance of accurate and timely diagnostics. The use of non-medical staff (outreach workers, peers) for the delivery of rapid testing is also mentioned as an effective practice to increase and facilitate access to testing in outreach settings.

Linkage to care

Linking individuals to care after diagnosis is a common theme across the documents. The linkage to care involves collaboration between various stakeholders, including harm reduction services, general practitioners, and specialists or hospitals. The emphasis on removing barriers and facilitating seamless transitions from diagnosis to treatment is consistent.

The frequent mention of specialised medical services underscores the complexity of treating hepatitis C and the need for expert care. This includes both inpatient and outpatient services that can address the full spectrum of needs associated with hepatitis C treatment.

Treatment approached and follow-up

The documents advocate for Direct-Acting Antiviral (DAA) treatment without limits and underscore the importance of End of Treatment (EOT) and Sustained Virological Response (SVR) as critical milestones.

The need for continuous follow-up after treatment is emphasised to ensure long-term success and address any emerging medical issues.

Less frequently mentioned, the importance of post-treatment care including EOT is noted but appears to be less emphasised. This suggests an opportunity to improve guidance on managing long-term health post-treatment and ensuring sustained treatment success.

Addressing stigmatisation and engaging the affected population

Stigmatization is recognized as a significant barrier, and strategies to address it are highlighted across all documents. Engaging the affected population, including people who use drugs, is deemed essential for successful interventions. The emphasis on involving peers, volunteers, and implementing training programs for key workers is consistent throughout.

Infrequently addressed, stigmatisation is recognized as a barrier to seeking treatment. The guidelines imply that increasing focus on this area could improve patient outcomes by fostering a more supportive healthcare environment.

Quality of services and collaboration

The EHRA's Components, Arguments, Criteria (CAC) tool contributes to understanding the quality of harm reduction services. It emphasises the need for multi-stakeholder consultation and scenarios for roundtable discussions, reinforcing the importance of collaborative efforts in designing effective interventions.

Harm reduction services are acknowledged as key elements in managing and preventing infectious diseases. Their frequent citation underlines the need for strategies that address the reduction of transmission risk factors.

Global guidelines and best practices

The WHO guidelines and the Compendium of Good Practices serve as valuable resources, providing a comprehensive overview of best practices at a global level. These documents stress the need for integrated services, the involvement of peers, and the establishment of partnerships between harm reduction facilities and medical centres.

Outreach and volunteer engagement

Though crucial for community trust and service extension, these areas are not as prominently mentioned, hinting at the potential benefits of community-driven initiatives.

End Of Treatment and follow-up care

The importance of post-treatment care including EOT is noted, but appears to be less emphasised. This suggests an opportunity to improve guidance on managing long-term health post-treatment and ensuring sustained treatment success.

Policy and strategic implications

Comprehensive and integrated policy for hepatic C prevention, testing and care should be implemented in all European countries and especially focus on addressing the needs of people who inject drugs. The key points should be community-based approach, integrating harm reduction principles into health care systems, adopt innovate care examples, equal access to high-quality hepatitis C testing and treatment, promote collaboration between all needed sectors, and make strategies to remove barriers, involve peer involvement and especially promote education for healthcare professions.

Feasibility and implementation

Systematic implementation of hepatitis C policy can be feasibly developed, tested, and scaled up, addressing the unique challenges faced by people who inject drugs and ensuring equitable access to high-quality prevention, testing, and care services across Europe. Regular monitoring, stakeholder engagement and input, and adaptability will be one of the most important factors to the success of this policy implementation.

Special remarks-Gaps

The guidelines point to certain areas mentioned less frequently. The special remarks noticed in the different documents were among others: screening and treatment uptake in prison, psychiatric care units/facilities. These are also places where people could easily be reached and treated if necessary.

5. Conclusions

The analysis of these documents collectively suggests that successful hepatitis C interventions for people who inject drugs require a multi-faceted approach. Collaboration between harm reduction/drug services, healthcare providers, and the active involvement of peers and volunteers is crucial. Additionally, addressing stigmatisation, ensuring the quality of services, and continuous follow-up are vital elements for the success of these interventions. These conclusions serve as a foundation for developing and enhancing strategies to increase access to BBV testing and care for this vulnerable population.

The conclusions focus on a comprehensive exploration of documents that aim to enhance access to hepatitis C testing and care, specifically targeting individuals engaged in drug injection practices. Sourced from reputable organisations such as EMCDDA, WHO, EHRA, and ECDC, this compilation offers an extensive array of insights, good practices, and evaluative tools designed to address the unique challenges within this demographic.

The main theme that pervades these documents revolves around the manifold services integral to the management of hepatitis C. The spectrum includes harm reduction services, addiction services, GP/health care services, specialised hospital care, general hospital care, outreach initiatives, mobile van services, and the indispensable role of HCV nurses. The recurrent inclusion of peers and volunteers underscores the imperative of adopting a collaborative, community-driven approach to navigate the intricacies associated with hepatitis C care among individuals with a history of drug injection.

A detailed study of the documents reveals a multifaceted evaluation criteria matrix. This encompasses critical dimensions such as awareness and prevention strategies, motivation for screening, the procedural aspects of screening, and a granular assessment of laboratory tests (including antibody and RNA testing). Noteworthy elements of evaluation further extend to the linkage to care, unrestricted access to Direct-Acting Antiviral (DAA) treatment, end-of-treatment (EOT) evaluations, sustained virological response (SVR), and the crucial aspect of comprehensive follow-up care.

Beyond the immediate focus on hepatitis C, these documents absolutely recognise the broader context of issues belonging to individuals involved in drug injection practices. Considerations cross other potential medical issues, the spectre of stigmatisation, and the development of engagement strategies specific to this demographic. The stress on engagement reflects an acute awareness of the significance of involving the affected community in the formulation and implementation of effective hepatitis C care strategies.

In essence, this summary serves as a comprehensive compendium, offering intricate insights into strategies, practices, and considerations for enhancing BBV testing and care among individuals engaged in drug injection practices. The varying evaluations contribute to a nuanced understanding of the multifaceted approaches outlined in each document, emphasising the need for a collaborative and adaptive strategy involving diverse stakeholders. This approach is deemed essential to effectively address the challenges associated with infectious diseases (focus on hepatitis C) within the specific and complex context of individuals engaged in drug injection practices. The emphasis on community-driven strategies, collaborative care, and the evolving landscape of evaluations collectively advocate for a person-centred approach in the pursuit of improved infectious diseases (hepatitis C) outcomes within this unique population.

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