Identification and optimisation of evidence-based HCV prevention in Europe for young drug users at risk

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European standards and guidelines for HCV prevention

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Abbreviations

AIDS  Acquired Immune Deficiency Syndrome
ARAS  Rumanian Association Against AIDS, Rumania
BASL  Belgian Association for the Study of the Liver
CARUD Centre d'accueil et d'accompagnement à la réduction des usages de drogue, France
DCR   Drug Consumption Room
DIMPS Dispositif d'Intervention Mobile pour la Promotion de la santé Sexuelle (Promoting safe sex and safe drug use in Luxembourg)
DPIP  Drug Prevention and Information Programme
EMCDDA European Monitoring Centre for Drugs and Drug Addiction
EPP   Exposure Prone Procedures (invasive procedures with risk for direct contact between the skin of a healthcare worker and for instance needles)
GP    General Practitioner
HCV   Hepatitis C Virus
IDU   Injecting Drug User
NSP   Needle and Syringe Programme
PCR   Polymerase Chain Reaction (for the diagnosis of the virus type)
PRELUD French survey on infectious diseases carried out among drug users utilising low threshold services
RKI   Robert Koch Institute
RNA   Ribonucleic Acid (to determine the viral load)
SerT  Servizi Tossicodipendenze, Italy
STD   Sexually Transmitted Disease
TERVE Health Promotion Research Programme, Finland
UNODC United Nations Office on Drugs and Crime
1 Aims and Responsibilities

The European project on prevention of hepatitis C among young drug users at risk is a transnational project, funded by the Drug Prevention and Information programme (DPIP) of the DG Justice of the European Commission. The project started at 1st of January 2010 and will have an overall duration of 24 months.

With regard to the DPIP priorities defined for 2008/2009 the project on HCV prevention will contribute to the exchange of information and good practice in the area of harm-reduction. In particular the design of the project is in line with the priority to enhance the prevention of viral infections among young drug users at risk for acquiring blood-borne diseases. In this respect the transnational project aims at raising the awareness for the need of effective hepatitis C prevention by the development of new prevention approaches.

Main objective of the project is to improve HCV prevention for young, not infected drug users in Europe. Closely related to this aim is the overall objective to contribute to the further development of innovative prevention approaches to reduce new infections with hepatitis C among vulnerable groups of drug users.

In response to the DPIP priorities and the project aims six different methodological activities will be implemented during the project period. These activities cover a compilation of international evidence on effective hepatitis prevention, the identification of national guidelines or standards in the European member states, the empirical evaluation of existing hepatitis C prevention programmes, national conferences and recommendations to optimise HCV prevention in harm-reduction.

One of the six activities consists of the identification and collection of national guidelines or standards for HCV prevention in each of the 27 European Member States and Norway. Originally it was planned to collect the identified guidelines and standards physically and to disseminate the documents to relevant harm-reduction networks and to the EMCDDA. However, when starting with the identification of existing HCV prevention guidelines and standards it became clear that

- most of the existing guidelines are rather on treatment than on prevention of hepatitis C infections, and thus
there is a need to describe the contents and aims of standards and guidelines on HCV prevention in order to share knowledge.

In view of the lack of knowledge on HCV prevention policies in Europe it has been decided not only to physically collect documents but to considerably expand the activities within this work package, and to compile a systematic overview on HCV prevention existing in the European Union Member States and Norway.

To identify, collect and characterise existing guidelines and standards for HCV prevention the partners shared responsibilities. Each partner was responsible for a defined number of countries out of the 28 European states. The responsibilities for the identification, collection and characterisation of guidelines and standards were as follows:

- **CIAR Hamburg** was responsible for Northern European countries: Germany, Austria, Denmark, Finland, Norway and Sweden
- **Catalonian Health Department Barcelona** was responsible for South-Western European countries: Spain, France, Italy, Malta and Portugal,
- **EHRN Vilnius** was responsible for Eastern European countries: Lituania, Bulgaria, Estonia, Latvia, Romania and Slovenia
- **KETHEA Athens** was responsible for South-Eastern European countries: Greece, Cyprus, Czech Republic, Hungary and Slovakia
- **Mainline Amsterdam** was responsible for the countries in the middle of Europe: The Netherlands, Belgium, Great Britain, Ireland, Luxembourg and Poland

In general, one aim of the expanded work package is to systematically search for national guidelines and standards specifically including information on the prevention of hepatitis C among drug users. A second aim is to provide a short characterisation of the national HCV prevalence, the policy on HCV prevention and the implemented harm reduction services for each Member State. A further objective is to compile a systematic overview on the contents of the existing national guidelines and standards.

The systematic overview required more human resources and time than originally planned. Instead of the planned six months the implementation of the activity needed eight months and each partner was involved in contacting a number of national experts and reporting on the countries.
2 Methods for the identification of guidelines, standards and policies

Basis for the identification of national guidelines and standards on hepatitis C prevention is a definition of "guidelines" on the one hand and "standards" on the other hand. The definition ensures a common understanding on what has to be searched for. In consideration of applied definitions for guidelines and standards (see for definitions: http://www.emcdda.europa.eu/themes/best-practice/standards) the following definitions have been adopted:

Guidelines for the prevention and control of infectious diseases and public health threats are comprehensive, systematically developed statements to improve the quality of professional practice and patient care. They aim at the improvement of quality and effectiveness of prevention approaches for the main population as well as for high-risk groups.

(Quality) standards are generally accepted principles or sets of rules for the best/most appropriate way to implement an intervention. Frequently they refer to structural (formal) aspects of quality assurance, such as environment and staff composition. However they may also refer to aspects of content, processes and evaluation of the intervention.

Apart from guidelines and standards is has been decided to consider as well national policies on HCV prevention. This decision was made as a country might have a specific policy to prevent infectious diseases among drug users even though there is no national guideline or standard available. Compared to guidelines a specific policy might have the same or even more impact on prevention practices.

2.1 Approaches to collect national guidelines, standards and policies for the prevention of hepatitis C

Three different approaches were used to identify and collect defined national guidelines and standards as well as policy papers for HCV prevention which are targeting at drug users. The three approaches were:

1. Search in online databases
2. Search in national reports submitted to the EMCDDA
3. Search through the use of a questionnaire which was sent to national experts
Policy documents were considered in case they address prevention of infectious diseases and deal with drug users. Guidelines on hepatitis treatment were included unless prevention is part of the guideline.

In the following the different approaches are described.

**Database search**

Guidelines and standards for the prevention of hepatitis C among drug users have been searched in a number of different databases, such as

- Databases on guidelines such as SIGN (www.sign.ac.uk), Cochrane, the German database “Science-based Guidelines for Diagnostics and Therapy” (www.leitlinien.net) or the “Clinical Practice Guidelines” of the European Association for the Study of the liver (www.easl.eu/_clinical-practice-guideline9)
- Online databases such as PubMed, Medline and Psychinfo
- Databases of relevant and specialised organisation and networks such as the Eurasian Harm Reduction Network (www.harm-reduction.org) and the WHO
- Websites of the EMCDDA and the national Focal Points
- Websites of the national governments, the health departments (such as from Slovakia: www.health.gov.sk) or of epidemiologic data (such as the Hungarian National Centre for Epidemiology: www.oek.hu/oek.web)

Each partner has screened the databases in order to identify HCV prevention guidelines and standards existing in the European countries they are responsible for. The search was documented as to the following items: name of the database screened, the date of search, the keywords used, the number of documents found and the number of those documents referring to HCV prevention guidelines or standards. Documents which have been identified as guidelines or standards were documented in details in terms of a reference list. These references include information on the country, title, year of publication, authors, the publishing institution and the website.

**Search of National Reports**

A further strategy to identify HCV prevention guidelines was to screen the national reports submitted to the EMCDDA. The yearly reports from the last five years (2006-2010) were searched for information on existing guidelines and standards. In addition the national reports were searched for the following information.

- epidemiological data on HCV infections among drug users,
- the existence of a national drug policy on HCV prevention, and
• the implemented harm reduction.

The reports screened as well as the guidelines or standards found for hepatitis C prevention have been documented in the same way as the database search described above.

Based on the search results and the country information collected, a country-by-country description of the national responses to hepatitis C infections among drug users is drawn (see chapter 4). The short characterisation of the European Member States and Norway provides information on the HCV prevalence among drug users, the national policy on HCV prevention and available harm reduction services. Furthermore it is stated if national guidelines and standards on hepatitis C prevention have been found by the searches.

**Questionnaire on national guidelines, standards and policies on HCV prevention**

In order to check whether there are national guidelines, standards or policies on HCV prevention, which have not been found through the searches in databases and in the REITOX national reports, national stakeholders and experts have been contacted. For this purpose a list of experts was compiled which is based upon the contacts already existing among the involved project partner. The list of experts names national experts for each of the 28 European States and was updated continuously. All project partners received the updated expert list in order to contact national experts of those countries each partner was responsible for.

To ask the national experts for guidelines, standards or policies on HCV prevention a questionnaire has been developed. The questionnaire “Request on HCV-prevention guidelines” is to collect information on type, interventions and target groups of the existing guidelines, standards or policies in a structured and comparable way. The questionnaire was sent to the national experts by email and designed to be filled in electronically. For each existing national document the experts were requested to fill in a separate questionnaire.

Each questionnaire sent and each expert addressed has been documented. The documentation includes information on the date the experts have been contacted, the number of questionnaires sent, and the number of questionnaires received. In case that there was no response from any of the experts contacted in a certain country, reminders have been sent by email. The date of the reminders has also been documented.

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All questionnaires received have been entered in a database. The database allows to develop a structured overview on HCV prevention policies and practices in the European Member States. The results of the information collected by the questionnaires are presented in chapter 3.

2.2. Results of the database search and the search of national reports

As has been described above for each of the 27 European Member States and for Norway databases were screened for guidelines, standards and policy papers on prevention of hepatitis C among drug users. 36 databases were searched for HCV prevention by using a variety of keywords, such as ‘prevention and hepatitis’ or ‘blood-borne diseases’ (table 1). In sum 7,400 documents were found which were then screened for addressing the issue of hepatitis C prevention. Out of the 7,400 documents no more than 35 documents were related to the prevention of hepatitis C (about 0.5 %). The 35 documents are related to 22 European countries.

Table 1: Results of the database searches

<table>
<thead>
<tr>
<th>Keywords used</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>“prevention and hepatitis C”; “harm reduction and hepatitis C”; “prevention and infectious disease”; “blood-borne diseases”; combinations of these keywords words with the name of the country were searched</td>
<td></td>
</tr>
<tr>
<td>Databases searched</td>
<td>36</td>
</tr>
<tr>
<td>Documents screened</td>
<td>7400</td>
</tr>
<tr>
<td>Documents related to HCV prevention</td>
<td>35</td>
</tr>
<tr>
<td>Countries covered by documents found</td>
<td>22</td>
</tr>
</tbody>
</table>

Countries with lack of documents on HCV prevention include Austria, Finland, France, Malta, Norway and Spain. Accordingly it turned out to be very important to involve national experts to collect comprehensive as well as most recent information on available policies and guidelines on HCV prevention.
2.3 Results based on responses of national experts

In the period from May 2010 to November 2010 information on existing national guidelines, standards and specific policy papers on the prevention of hepatitis C for drug users have been collected from national experts. Originally it was planned to limit the timeframe for the experts’ responses to the end of August 2010. However, it became necessary to expand the response period in order to increase the response rate.

To collect information from as many European countries as possible altogether 120 national experts have been contacted from May to November 2010 (table 2). These experts have been sent 111 questionnaires to request information on national HCV prevention guidelines, standards or policy. In case that none of the experts addressed in a specific country did respond to our request, ‘reminders’ were sent to the experts. In sum 27 reminders were sent by email. Out of the 111 questionnaires distributed altogether 42 questionnaires were returned by email. The questionnaires received cover 23 out of the 28 European States; this can be regarded as a very high response rate. Until the end of November 2010 there was no response from the five countries Finland, Ireland, Latvia, Malta and Romania.

Table 2: Number of experts contacted and questionnaires received

<table>
<thead>
<tr>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>National experts contacted</td>
</tr>
<tr>
<td>Reminders sent by email</td>
</tr>
<tr>
<td>Questionnaires sent</td>
</tr>
<tr>
<td>Questionnaires received</td>
</tr>
<tr>
<td>Questionnaires providing information</td>
</tr>
<tr>
<td>European countries responding</td>
</tr>
<tr>
<td>European countries providing information</td>
</tr>
</tbody>
</table>

Not all questionnaires received include information on national documents related to HCV prevention. To know about countries where no guidelines, standards or policy papers on HCV prevention exist, the first question in the questionnaire is if there are such documents available\(^2\). In case that no national documents on the prevention of hepatitis C exist, the experts have been asked to return the questionnaire anyhow.

\(^2\) The respective question in the questionnaire is: “To my knowledge there are no guidelines/ standards/ national policy papers on HCV prevention available”.

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Due to this procedure nine questionnaires have been excluded from the database. Three questionnaires were excluded because the national experts from Bulgaria, Estonia and Norway stated that there is no guideline, standard or policy paper on HCV prevention in their country. Consequently the number of countries with available documents on HCV prevention reduced from 23 to 20.

Further six questionnaires had to be excluded from the database as experts also stated that there are no documents related to HCV prevention available. These are questionnaires from France (-1), Italy (-2), Portugal (-1), Poland (-1) and Slovakia (-1) were not considered. However, other experts from the same countries reported on existing guidelines, standards or policy on the prevention of hepatitis C which are considered for analyses. It has to be mentioned that the different statements of the national experts from these five European countries are a results of the different understanding of HCV policy papers. While some experts refer to the National Drug Strategy as a policy paper covering HCV prevention for drug users, other experts have a more specific definition of a HCV prevention policy paper and do not consider the National Drugs Strategy as to be specific.

However, after excluding the questionnaires which do not provide any information there remain 33 questionnaires which provide information on HCV prevention for in sum 20 European countries.

2.4 Database of the overview by combining the search results

For the overview on HCV prevention in the European Union and Norway both the results of the database searches and the results of the questionnaires are considered. For this purpose the respectively identified national documents on HCV prevention are compiled to one database. The database allows to control overlaps in the identified guidelines, standards and policy papers resulting from the questionnaires and the database search. On basis of the database searches 35 national documents related to HCV prevention were identified and 33 documents were collected with the questionnaire (table 3). 23 out of the 35 documents found through the database search are the same as collected with the questionnaire. Consequently by the database searches in sum 12 documents were identified in addition to 33 documents identified with the questionnaires.

As not all documents collected by the database search and the questionnaire specifically focus on HCV prevention, the database was adjusted by sorting out all documents which do not address the issue of HCV prevention. However, documents focussing on HCV treatment are considered for further analyses if they include relevant aspects of HCV treatment.
prevention. With regard to the database adjustment all documents which merely refer to the national drug policy such as the National Drug Strategy or the National Drug Action Plan are excluded. For this reason 12 documents were sorted out. A further document was excluded because it is basically a guideline on opiate treatment. After sorting out altogether 13 documents the database is reduced from originally 45 documents to 32 documents. Most of the remaining 32 documents were identified by the questionnaires and seven of the documents result from the database search. The 32 documents which build the basis for the overview cover 16 European countries.

Table 3: Identified guidelines, standards and policy paper on HCV included in the overview

| Number |
|------------------|-------------------|
| **Compilation of the documents identified** | **Number** |
| Documents identified by the database search | 35 |
| Documents identified by the questionnaires | 33 |
| Documents being double counted | 23 |
| Remaining documents after excluding double counting | **45** |
| (n=33 through questionnaire and n=12 through databases) |
| Countries covered | **25** |

| Adjustment of the database by excluding all documents which are |
|------------------|-------------------|
| - only related to the National Drugs Strategy |
| - not related to specifically to HCV prevention (e.g. opiate treatment) | (exclusion of 13 documents) |
| Documents only identified by the database search | 7 |
| Documents only identified by the questionnaire | 16 |
| Documents identified by both resources | 9 |
| Documents considered for the overview | **32** |
| Countries covered | **16** |

With regard to the overview, presented in the next chapter, the following 12 European countries are not covered: Bulgaria, Cyprus, Estonia, Finland, Malta, Norway, Latvia, Lithuania, Luxembourg, Poland, Romania and Slovakia.
3 Results: Overview on guidelines and policies on HCV prevention existing in Europe

The overview on guidelines and policies on HCV prevention in Europe is based on 32 documents which have been identified through questionnaires and database searches. Out of the 32 documents the respective information results from 25 questionnaires and 7 documents found by database search. With the 32 documents collected 16 European countries are covered. These are:

- Austria (AT), Belgium (BE), Czech Republic (CZ), Germany (DE), Denmark (DK), Greece (EL), Spain (ES), France (FR), Hungary (HU), Ireland (IRE), Italy (IT), the Netherlands (NL), Portugal (PT), Sweden (SE), Slovenia (SI), and United Kingdom (UK)

Details of the national documents, such as title, author, and year of publication, are listed in Annex 2 at the end of the report.

Due to the lack of information (five countries) or the absence of any national document on HCV prevention (seven countries) in sum 12 European countries are not covered in the overview. These are:

- Bulgaria, Cyprus, Estonia, Finland, Malta, Norway, Latvia, Lithuania, Luxembourg, Poland, Romania, and Slovakia

In view of the countries covered by the overview first important results can be deduced. The majority of the European Member States has developed a specific response to the control, prevention and management of hepatitis C infections. If considering solely the 23 European countries which provided information it becomes apparent that in almost 70% of the European countries (16 out of 23) either guidelines, standards or a specific policy approach has been developed to address the health problem related to the high prevalence of HCV infections among drug users. On the other hand in particular the countries which joined the European Union in the period of the Eastern Enlargement in 2004 and 2007 seem to have not yet established a specific national policy to deal with hepatitis C infections among drug users.

Some years ago a project was conducted to collect European guidelines for the treatment of hepatitis C infections in IDUs. Even though the study was carried out before the Eastern enlargement and is focussed on HCV treatment, the findings give an idea about approaches to HCV infections in 2004 and in 2010. The results of the HCV treatment
study, published in 2005, show that out of the former 15 European Union Member States and Norway official or semiofficial guidelines on HCV treatment were found in nine European countries (Reimer, Schulte et al. 2005). Accordingly in slightly more than in half of the European countries guidelines for the treatment of HCV infections in drug users have been developed. Given the fact, that in 2010 in about 70 % of the European Union countries guidelines and a policy on HCV prevention exists, Europe seems to have become increasingly aware of the need to address the problem of HCV infections. Surprisingly in Norway and Finland semiofficial guidelines for HCV treatment existed already in 2004, however in both countries there exist no national guidelines or standards on HCV prevention so far.

3.1 Types of documents collected on HCV prevention

Of the 32 documents collected on HCV prevention all but five documents from Spain are national documents. In Spain there are regional guidelines relevant for the regions Catalonia and Galicia, and for the Communities of Valencia and Madrid.

Most of the documents collected are guidelines. This is the case for 17 documents (figure 1). Nine of the documents are characterised as policy paper and further five documents are practice standards. In relation the 16 European countries the analysis shows that in 10 of the countries guidelines for HCV preventions exist (figure 2). Furthermore, in five countries standards have been defined and in four countries policy papers are available.

In general the guidelines and standards are focussed on a range of different topics while the policy papers are more homogenous in their thematic orientation. For instance in
Austria there is a guideline for the HCV treatment of drug addicts. This guideline includes also aspects of HCV prevention, and is a result of a consensus conference of the Austrian Society for Gastroenterology and Hepatology. In Slovenia there is a consensus guideline for the management of hepatitis C in drug addicts, in Spain one guideline is focussed on the prevention and control of hepatitis C, and in the Netherlands a national guideline on proceedings in case of needle stick injuries has been developed. As regards policy paper, most come from the UK and from Wales, Northern-Ireland and Scotland respectively. In these regions action plans for the prevention, management and control of hepatitis C have been launched (for more details see Annex 2).

In general, most of the 16 European countries have produced one national document on HCV prevention, which is predominately a guideline (figure 3). The country-by-country data analysis highlights some national peculiarities. In Greece, Sweden and France merely policy paper on HCV prevention exist. While in Greece a national Action Plan (2008-2012) for the prevention of infectious diseases has been launched, in Sweden and France there are governmental decrees for combating communicable diseases such as HIV and HCV. Furthermore it has to be mentioned that in Austria one guideline and two standards have been developed which are all predominately focussed on aspects of HCV treatment for drug addicts. Among the 16 European countries Spain and the United Kingdom have developed the most solid national responses to the health problem of infections with hepatitis C. In Spain there are six guidelines covering a range of topics from the control of HCV infections to clinical treatment of HCV. In the UK seven documents exist – five policy papers, one guideline and one standard. The guideline deals with testing for hepatitis C.

**Figure 3: Number of HCV prevention documents (n=32) by type and country (n=16)**
The national documents on HCV prevention have been published between 1998 at the earliest and 2010 as most recent documents. Details concerning the year of publication reveal that in 2004, 2007 and 2010 with six and respectively five documents there is a peak in publication of national guidelines or policy paper on the prevention of hepatitis C (figure 4). In 2004, four guidelines, one standard and one policy paper were published. Similarly in 2007 and 2010 four and respectively three national guidelines addressing the prevention of hepatitis C were published. In view of the publication date the main result is that about one third of the national documents on HCV prevention have been published most recently in last three years from 2008 to 2010.

Figure 4: Year of publication by type of document (n=32)

Figure 5: Language of the documents related to HCV prevention
Due to the language diversity in Europe it is no surprise that out of the 32 documents collected the majority of 22 documents are written in a non-English language (figure 5). Only 10 documents are available in English language of which seven documents are from the UK, one is from Ireland and two are from Belgium.

### 3.2 Objectives and approaches of European HCV prevention

With regard the objectives of the documents related to HCV prevention the most important question is whether the documents include information on specific objectives or not. The analysis clearly shows that in the majority of the documents on HCV prevention the objectives are specified (figure 6). Only in 7 out of 32 documents there is either no information or the objective is not specified.

**Figure 6: Specification of the objectives by type of document (n=32)**

The questionnaire differentiates three categories of specified objectives. These are:
- Recommendations for appropriate risk reduction for a specific health problem or target group (OB3)
- Improvement of prevention and control of the spread of infectious diseases (OB4)
- Other, specify (OB5)

One document may address more than one objective, and accordingly multiple choices are possible. A detailed evaluation reveals that the three specific objectives are mentioned to an almost equal extent (figure 7). The guidelines aim at providing recommendations for risk reduction as well as at the improvement of prevention of infectious diseases. Both objectives are mentioned eight times each. Furthermore in 11 cases the guidelines have
other objectives which are in most cases to define medical criteria for the management and treatment of hepatitis C. For instance, the Scottish guideline provides best practice recommendations for commissioners and injecting equipment provision services in Scotland. In Germany, the guideline on HCV prevention is targeted at the establishment of standards for prophylaxis, diagnosis and therapy of HCV infections in order to reduce new infections, to avoid the complications of chronic hepatitis, and to adopt evidence-based antiviral therapies.

**Figure 7: Specific objectives related to HCV prevention by type of document (n=32) – multiple choices**

![Bar chart showing specific objectives by type of document (n=32)](image)

Similar to guidelines also standards aim at both the recommendation of strategies for appropriate risk reduction for a specific health problem or target group, and the improvement of the prevention and control of the spread of infectious diseases. To give an example: The Portuguese standard consists of two major components – the theoretical and the practical description of harm reduction. In the theoretical chapter definition, objectives and methods of harm reduction are outlined, and in the chapter on practice the focus is on the identification of drug-related risks, and guidelines for counselling and the management and prevention of health risks.

On the other hand policy papers tend to be more likely to aim at the improvement of the prevention and control of blood-borne diseases. For instance, in France the policy paper on risk reduction for drug users aims at the improvement of hepatitis B vaccination, screening for hepatitis B and C, the access and quality of care for infected patients, and
specific prevention actions for prisoners. In Wales the action plan is targeted at the provision of a clear, costs and time defined framework for the planning and provision of key services to reduce the transmission of blood borne hepatitis infection and the pool of undiagnosed infections. Further aims are to improve the provision of treatment and support to infected individuals, and to monitor and evaluate treatment and prevention programmes in Wales.

Most of the guidelines on HCV prevention follow the approach of selective prevention and target either at specific risk groups such as IDUs or at infected individuals (figure 8). Only in seven cases guidelines are in line with general prevention of infectious diseases. Policy paper show a similar picture: these documents also are more likely to focus on selective prevention rather than on general prevention. Policy paper follow in 15 cases selective prevention approaches and in six cases general prevention approaches. Finally standards for the prevention of hepatitis C cover both selective prevention – for risk groups and /or for infected individuals – and general prevention to an equal extent.

Altogether five documents – three from the UK and respectively one from Austria and Portugal – mention further important approaches related to HCV prevention. In the UK documents monitoring of HCV testing and the importance of pre-and post-test counselling is stated. In Portugal testing for HCV and vaccination for hepatitis B is reported as an important part of prevention, and in Austria treatment for prison inmates is mentioned as part of prevention.

Figure 8: Prevention approaches by type of document (n=32) – multiple choices
If focussing on the European countries the following prevention approaches are applied:

- eight countries have developed HCV prevention documents on both general and selective prevention (Belgium, Denmark, France, Greece, Spain, the Netherlands, Slovenia and UK)
- six countries have developed documents only for selective prevention (Austria, Czech Republic, Germany, Ireland, Italy, and Sweden)
- two countries have developed HCV prevention documents which are only based on general prevention (Hungary and Portugal).

Most European countries address the problem of HCV infections by both general prevention and selective prevention.

### 3.3 Interventions covered, target audience and risk group addressed

The aim to prevent infections with hepatitis C among drug users can only be achieved by offering drug users highly available and accessible interventions which are suitable to minimise risk behaviour through blood contact. Within the current European study altogether 11 different interventions are regarded as most important to prevent infections with hepatitis C. These interventions are

- needles and syringe exchange programmes and drug consumption rooms,
- testing for HCV and vaccination for hepatitis A virus (HAV) and hepatitis B virus (HBV),
- all types of interventions to promote risk awareness such as advice on safer use and safer sex, health education, blood awareness, and risk assessment, and
- treatment for infections with hepatitis C as part of prevention of blood-borne diseases.

With respect to the countries one important question was which types of interventions are covered by the available national guidelines, standards and policy papers on HCV prevention. The data analysis reveals that all but one country (Portugal) address testing for hepatitis C in at least one of their national documents on HCV prevention (table 4). Similarly, with exception of Austria all European countries specify health education or health promotion as important for prevention of hepatitis C. Second most often is vaccination for HAV and HBV which is named by 14 out of 16 countries. This is followed by advice on safer use and by treatment for HCV which respectively 13 countries mention as part of prevention for hepatitis C.

Interventions which seem to play a minor role in the prevention of hepatitis C are risk assessment, risk awareness and blood awareness. Risk assessment is part of the
counselling related to the testing for HCV. Risk awareness is specified as promoting the aware-ness for risks of infections occurring though tattooing and piercing, and blood awareness is an umbrella term for campaigns or short interventions such as hand wash-ing which aim at drug users to avoid direct blood-to-blood contact. These three interven-tions are named by only about half of the 16 countries.

Drug consumption rooms as service to prevent infections with hepatitis C are solely em-phasised in Germany and the Netherlands. Drug consumption rooms are still not wide-spread in Europe, and at present they exist in Germany, Netherlands, Spain, Luxembourg and Norway.
<table>
<thead>
<tr>
<th>Intervention</th>
<th>AT</th>
<th>BE</th>
<th>CZ</th>
<th>DE</th>
<th>DK</th>
<th>EL</th>
<th>ES</th>
<th>FR</th>
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<tbody>
<tr>
<td>Needle and syringe exchange</td>
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<td>Vaccination for HAV / HBV</td>
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<tr>
<td>Drug consumption rooms</td>
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<td>Health education /promotion</td>
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<td>Blood awareness</td>
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<td>Risk awareness (tattoo)</td>
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<td>HCV treatment</td>
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In a further step it is analysed whether the guidelines, standards and policy papers show differences in the types of interventions covered. The results show that national guidelines on HCV prevention clearly focus on testing for HCV and on treatment of HCV infections (figure 9). Secondly, guidelines set priorities in vaccination for hepatitis A and B, and in health education of drug users. Standards for HCV prevention place to a similar extent emphasis on HCV testing and treatment, vaccination for hepatitis A and B and health promotion. Similarly, policy papers predominately cover these four interventions. In addition they stress the importance of syringe exchange programmes.

**Figure 9: Interventions specified for HCV prevention by type of document – multiple choices**

For example, the Slovenian guideline covers the diagnosis, prevention, treatment, and follow-up of hepatitis C among drug addicts treated at one of the 18 centres for prevention and treatment of drug addiction. In Scotland, the policy paper is concerned with the provision of needles, syringes and other injecting paraphernalia to people who inject opioids, stimulants, and other illicit substances.

In conclusion, guidelines, standards as well as policy papers obviously prioritise the four interventions – HCV testing, vaccination for HAV and HBV, health education and HCV treatment – as most appropriate to control and prevent infections with hepatitis C. There are only two differences between the specific types of documents: Policy papers also address needle and syringe exchange within the context of HCV prevention while a number of national guidelines deal with risks related to tattoo and piercing.
The majority of the documents on HCV prevention specify the target audience which comprises stakeholders or professional organisations who should make use of the guideline, standard or policy paper. Out of the 32 documents only two documents – one guideline and one policy paper – do not provide information on the target audience. Guidelines on HCV prevention predominately are directed to physicians (in 14 cases), followed by health care professionals or social professionals (in 9 cases) (figure 10).

Furthermore in seven cases guidelines are (also) targeted at service provider. Standards for provision of HCV prevention most often address physicians, health care and social professionals, and service providers. On the other hand most of the policy papers are directed to health care planners, followed by health care professionals. In addition, in five cases politicians belong to the target audience of policy paper.

**Figure 10: Target audience specified for HCV prevention by type of document – multiple choices**

On a national level, 13 of the 16 countries provide documents on HCV prevention for health care or social professionals (exceptions are Austria, Ireland and Sweden). Respectively in eleven countries there are documents targeting at physicians and service providers. For instance, the Czech standard for the diagnosis and treatment of chronic HCV infection is recommended to be used by the Czech Hepatology Association, the Czech Medical Association and Czech Ministry of Health. In Ireland, the guidelines contain advice for GPs on all aspects of care of patients at risk of HCV, including appropriate evaluation prior to referring a patient for assessment to a hepatology unit.
In eight countries - Denmark, France, Greece, Italy, the Netherlands, Slovenia, Sweden, and United Kingdom – documents on HCV prevention are directed at health care planners. Politicians are addressed in the six European countries Belgium, France, Greece, Slovenia, Sweden, and the United Kingdom. Finally in Belgium, Hungary and the Netherlands clients belong to the target audience of the national documents. In Belgium the Steering Committee of the BASL stated that the recommendation for screening, treatment and prevention of hepatitis C should be of use for medical specialists, general practitioners and patients.

Along with the target audience it is of major interest to know who belongs to the risk group covered by the national document on HCV prevention. In this respect it has to be mentioned that only one guideline from Spain does not specify the risk group; the guideline is on monitoring and treatment procedures and addresses the HCV infected population.

Among the remaining 31 documents with a specification of the risk group addressed the vast majority of the documents are on HCV prevention specifically for the high risk group of intravenous drug users (figure 11). This is the case for guidelines as well as for standards and policy papers.

**Figure 11: Risk group specified for HCV prevention by type of document – multiple choices**

Second most often guidelines and standards include recommendations for early prevention aiming at those drug users who are not infected with hepatitis C. Policy paper second most often address also prisoners with measures to prevent HCV infections. The category of “others” comprises specifications of the risk group such as ‘at risk population’ (UK
policy paper), ‘general population’ (UK policy paper), ‘individuals infected with hepatitis C’ (Greek policy paper, UK standard), ‘Non-IDUs’ (French policy paper), ‘victims of needle stick injuries’ (Dutch guideline), and ‘cocaine users’ (Spanish guideline).

In all countries the risk group of IDUs is addressed by the national strategies for HCV prevention. In nine countries the risk group for HCV prevention consists of non-infected drug users. Prisoners are specifically mentioned as risk group in seven countries. In Europe, the risk groups of young drug users, sex workers and migrants do not seem to play a role in HCV prevention. Only in four countries respectively the national documents on HCV prevention also address at least one of these risk groups. These countries are:

- Young drug users: Spain, Italy, Slovenia and the United Kingdom
- Migrants: Greece, Italy, Sweden and the United Kingdom
- Sex workers: Belgium, Greece, Spain and Sweden

To sum up: Prevention for hepatitis C should primarily be achieved by the provision of HCV testing, vaccination for HAV and HBV, health education and HCV treatment. Guidelines on HCV prevention are predominately directed to physicians, while policy papers most often are directed to health care planners. Standards for provision of HCV prevention mainly target at both physicians and health care and social professionals. However, guidelines, standards and policy paper on HCV prevention predominately aim at the risk group of intravenous drug users.

### 3.4 Setting for prevention of hepatitis C

One question of the questionnaire was, if the national guidelines, standards, or policy papers on HCV prevention are directed to a specific setting. Respective answer options are that the documents do either not specify the setting for HCV prevention or that they are directed to community and / or prison services.

The analyses indicate that most of the documents related to HCV prevention are directed to community services (figure 12). In addition, four guidelines and policy papers respectively are addressing prison services. It has to be mentioned that these documents usually mention both community and prison services. There are only two documents which are specifically focussed on prison services. One is a standard from Austria dealing mainly with the treatment of inmates who are HCV-positive. The other one is a guideline from Spain which describes requirements for the coordination of HCV treatment within prison services. Out of the 32 documents only three guidelines and three policy paper are not directed to a specific setting.
With regard to the community setting further distinctions are made as to the service area. Thus, the community setting includes the general health care such as hospitals, office-based physicians, drug agencies as specific services for drug users, and harm reduction services as specific approach to the risks related to drug use.

Within the context of community services guidelines for HCV prevention are clearly directed to the general health sector (figure 13). This result is in line with guidelines mainly targeting at physicians. Standards are targeted at the general health care and at drug agencies to an equal extent. Policy papers do not tend to favour a specific area but address the health sector, drug agencies and harm reduction services. The balanced orientation of the policy papers is no surprising result as it is in the nature of policy strategies.

The national documents from Germany, Greece and Sweden do not provide further information on the target area of community services. If focussing on the country level, the
analysis shows: In 10 out of 16 countries community prevention of HCV is directed to the health sector (AT, BE, CZ, DK, ES, IT, IRE, NL, SI, UK). In 8 countries community services are directed to harm reduction services (DK, FR, HU, IT, NL, PT, SI, UK). Furthermore in six countries community services for HCV prevention cover drug agencies (HU, IT, NL, PT, SI, UK).

3.5 Development group and basis of the documents on HCV prevention

At the end of the overview on national HCV prevention the attention is drawn to two questions:

- Who has developed the guideline?
- What is the basis for the definition of strategies or actions for HCV prevention?

In most of the guidelines, standards and policy papers on HCV prevention the members of the developing group have been reported. Only in three policy papers (two from France and one from the United Kingdom) and in two guidelines (one from the Netherlands and one from Spain) information on the development group is missing.

The 27 documents have been developed by the following groups: Guidelines on HCV prevention were predominately developed by physicians (figure 14). The second main group involved in the guideline development consists of professionals from health and social care and of researcher. Standards were mainly developed by the two groups of physicians and professionals from health and social care. Policy papers are based on the involvement of a range of different experts and stakeholders. Health and social professionals as well as politicians and researcher and physicians belong to the group which has developed the policy paper.

However, often a number of different stakeholders belong to the group of those developing the document on HCV prevention. In Slovenia, for example, the guidelines are based on the consensus of infectologists, gastroenterologists, psychiatrists, drug addiction specialists, virologists, epidemiologists, pathologists, and social workers.
Clients are solely part of the group in the policy paper from Wales which is entitled “Blood borne viral hepatitis action plan for Wales 2010 – 2015”. The category ‘other’ refers to service provider in case of one guideline from the UK. Furthermore ‘other’ appears in two policy papers - from Greece and one from Sweden. In Sweden a governmental inquiry committee and in Greece public servants and consultants belonged to the group which has developed the national policy paper on HCV prevention.

Altogether in 13 out of 16 European countries physicians were involved in the preparation of the national document. Professionals of health and social care belonged to the development group in 12 countries. Researchers were part of the group in seven countries (BE, CZ, DE, IT, NL, SE, UK) and politicians belonged to the group in three countries (EL, SE, UK).

The majority of the guidelines, standards and policy papers on HCV prevention are based on both expert consensus and evidence (figure 15). This is the case in 15 out of 17 guidelines and in four out of six policy papers. Only four of the 32 national documents are mainly based on expert consensus, and only one national policy paper is primarily based on available evidence from research. The latter is the case for the Scottish hepatitis C action plan, phase II. With respect to the expert consensus documents on HCV prevention, it is worth providing some details:

- In Austria, expert consensus is related to a standard for the HCV treatment of prison inmates.
In Denmark the national guideline basically includes standards and procedures for the health staff of community treatment centres for IDUs on the modus of testing, counselling, vaccination and treatment of hepatitis A, B and C and HIV. Given these facts, the guideline is more to be perceived as an operating standard.

In UK-England the expert consensus builds the basis for the hepatitis C action plan for England. One of the documents was published for consultation in implementing the HCV strategy. The other document has been developed to support health care professionals in the implementation of the hepatitis C action plan.

**Figure 15: Basis of the national documents on HCV prevention**

It has to be mentioned that three standards and three policy papers do not provide any information if they are based on expert consensus or evidence. In consideration of these documents, it becomes apparent that they do not fit in the categories of guidelines, standards or policy papers. For instance one of the documents is from Austria and classified as standard. However the Austrian expert stated that the document is a list of recommendations concerning the appropriate intervention for IDUs as regards vaccination, diagnosis, and treatment for hepatitis. In France, one of the national policy documents is a governmental decree which sets up a reference document on harm reduction to be provided in France. With regard to the prevention of infectious diseases among IDUs harm reduction has to include the distribution of sterile drug use equipment, education and screening for hepatitis and vaccination for hepatitis B. In Hungary, the national standard on HCV prevention is a short guide for health care workers on screening and counselling of drug-related infectious diseases (HIV, hepatitis B and C) which is offered to IDUs.

Available evidence from research is considered systematically in the majority of the guidelines, standards and policy papers (figure 16). In 24 out of the 32 documents evidence is considered at least in part; in 18 of these documents evidence has largely been considered. Only the policy paper from Sweden does not take available evidence into account.
According to the expert the national document is a government bill (approved in 2006) which includes a general strategy for the prevention of HIV infection and other sexually transmittable and blood-borne infections. The bill comprises special sections on the prevention strategy for IDUs.

**Figure 16: Scope of systematic consideration of available evidence**

There are altogether seven documents which do not provide any information about the issue if evidence has been taken into consideration. This is the case for the three documents from Austria, the two policy papers from France, the HCV action plan from Northern-Ireland and the Hungarian standard on HCV prevention.

If evidence has been considered, it has also been reported in the national document. Only in one standard the evidence considered has not been reported.

To summarise the main results: Guidelines on HCV prevention are primarily developed by physicians while standards are mainly developed by both physicians and professionals from health and social care. Policy papers are based on the expertise of health and social professionals, politicians, researcher and physicians. Altogether 21 out of 32 documents on HCV prevention are based on both expert consensus and scientific evidence. In 24 of the national documents evidence has at least partly considered.
Country Reports: National policies and interventions for HCV prevention among drug users

Before presenting the national policies on HCV prevention for each country, the national prevalence of HCV infections among drug users is presented. The following figures indicate the prevalence rates separately for drug users in general and for drug injectors in particular. The prevalence rates have to be treated with caution as they represent the latest number of drug users with hepatitis C infections

- reported either by either a number of drug services or
- which are based on nationwide samples of blood tests among different populations.

Figure 17: HCV infections among opiate users – by country

In a number of countries the prevalence reported for HCV infections among drug users covers a broad range such as from 29% to 75% (Denmark), as the prevalence depends on the source of information. In general, the prevalence reported differs if it is based upon the national treatment register, a sample of regional research studies, clinical blood samples, testing results achieved by low-threshold drug services, and so on. In case the reported HCV prevalence shows a huge range, the median percentage has been used in the figures.
4.1 Austria

National prevalence of HCV among drug users

The most current data on HCV prevalence rates indicate a remaining high level of infections with hepatitis C. While among drug users the HIV prevalence remained at a low level ranging from 0 % to 2 %, the hepatitis C prevalence is around 50 % in 2009. The prevalence rate of hepatitis B in the drug using population is lower than 20 % (Reitox National Focal Point AUSTRIA 2010).

In Austria, positive testing is based on HVC antibody test and PCR tests, both being documented separately by a few drug treatment units. National as well as subnational samples from low-threshold centres and inpatient treatment units show that in 2008 HCV antibody prevalence rates ranged from 22 % to 60 %. The huge variety in the HCV prevalence rates results from the different at-risk groups contacting the drug services, and from the fact, that there are partly voluntary tests and partly mandatory tests. However, a solid interpretation of the prevalence rate is more or less impossible.

National drug policy on HCV prevention

In Austria, there is no national strategy or policy specifically on HCV prevention. However, the Austrian report to the EMCDDA (Reitox National Focal Point AUSTRIA 2010) refers to actions targeting at HCV prevention. The implemented actions are directed to the prevention and treatment of drug-related infectious diseases, such as hepatitis and HIV/AIDS.
Blood-borne diseases among drug users are mainly addressed through harm reduction measures such as substitution treatment, needle exchange programmes, needle exchange vending machines, and through outreach work.

In Austria, there are two consensus guidelines for the treatment of chronic hepatitis C among drug use. Both consensus guidelines have been developed by addiction medicine. The first one was developed in 2000 in close cooperation of the Ministry of Health and 16 experts from hospitals, outpatient clinics, surgery, administration, and treatment units. The consensus includes a definition of criteria for counselling, diagnosis and especially for the treatment of HCV-positive drug addicts (Haltmayer, Tanzmeister et al. 2001). The second consensus paper was an update of the consensus from 2000. The updated treatment consensus does not specifically address drug users but HCV-infected individuals. It was published in 2004 by the Ministry of Health.

In 1998, the highest medical advisory board of the Austrian Ministry of Health defined the criteria for medical care provided for drug addicts who are infected with hepatitis C. The paper on medical care is a result of a working group on drug addiction and hepatitis.

**Harm reduction to prevent infectious diseases among drug users at risk**

Similar to many other European countries, harm reduction measures are the main response in Austria to prevent infectious diseases among intravenous drug users (IDU). Many harm reduction measures are offered in low-threshold centres and through outreach work. At present the following harm reduction services are available (see the Austrian National Report 2010).

*The exchange and sale of syringes* is one important service to reduce blood-borne virus infections. Sterile syringes are available at provincial level, and drug users can get their injecting equipment either at specialised drug series or in pharmacies. The services provided by the specialised drug services have been expanded. *Safer use and safer sex* are essential issues provided to drug users through outreach work, usually on the occasion of syringe exchange. In 2008, the drug services of Vienna published a guidebook for drug users on risks of injecting drug use and alternatives to intravenous drug use. The guidebook also includes information on different substances and on safer sex (VWS 2009).

*Hepatitis vaccination* is a further essential intervention to prevent drug-related infectious diseases. Provided at regional level, hepatitis vaccination is most often combined with cost-free HIV and viral hepatitis testing. According to the nationwide documentation system of the drug services clients, 420 drug users received vaccinations for hepatitis A and
569 drug users received vaccinations for hepatitis B in the year 2009. These numbers result in a vaccination coverage of 28 % for hepatitis A and 31 % for hepatitis B (Reitox National Focal Point AUSTRIA 2010). Also treating infectious diseases in drug users has become increasingly important in the whole country.

Opioid substitution treatment (OST) represents the most important type of treatment for opiate addiction in Austria, and efforts to improve it have continuously been made. According to the Austrian national report (2010), in 2008, 11.057 patients have been in opioid substitution treatment.

4.2 Belgium

National prevalence of HCV among drug users

Since 1990, in Belgium blood and blood products for transfusions are checked on HCV. Since 1995 doctors have to report all newly detected HCV-infections. The Belgian surveillance network for infectious diseases registers hepatitis cases through around a hundred microbiology laboratories spread in Belgium. However, the data do not include information on relations to drug use.

The prevalence of hepatitis C in Belgium is approximately 1 % (Robaeys, Bottieau et al. 2005; Belgische Senaat 2008; Belgische Senaat 2010). Since only Flanders reports all cases and Wallonia and Brussels report only acute HCV-infections, the total number of infections might be higher. In 2001, the prevalence in prison in the French community was almost 28 % (see Table INF-108 from the EMCDDA Statistical Bulletin 2010). In 2007, the prevalence of hepatitis C infection among injecting drug users in Flemish community is about 34 %. The prevalence among injecting drug users under the age of 25 is 10 %.

More recent data (see the table below) is provided in the 2010 national report submitted to the EMCDDA (Reitox National Focal Point BELGIUM 2010).

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3 Table INF-108 is available at http://www.emcdda.europa.eu/stats10/inftab108
Prevalence hepatitis C infected among IDUs asking for drug treatment in 2003-2008

<table>
<thead>
<tr>
<th>Drug treatment centre</th>
<th>Proportion of treatment clients tested (%)</th>
<th>% of HCV-positive tests</th>
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</thead>
<tbody>
<tr>
<td>Flemish centre “De Sleutel”</td>
<td>38</td>
<td>27</td>
</tr>
<tr>
<td>French treatment centres</td>
<td>29</td>
<td>47</td>
</tr>
<tr>
<td>Free clinic Antwerp (2003-2007)</td>
<td>60</td>
<td>82.7</td>
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</table>

National drug policy on HCV prevention

In Belgium, there is no national policy specifically for the prevention of hepatitis C. However, there are organisations for patients infected with hepatitis C: The organisation in Flanders is called “VHC”, the organisation in Wallonia is called “CHAC”. Together with the Belgian Association for Study of the Liver (BASL) both organisations are active in public campaigns addressing the general population and the general practitioners.

BASL formulated guidelines for screening, treatment and prevention of HCV-infections (Michelsen, Brenard et al. 2003) According to this guideline mass screening for HCV is very expensive and therefore not cost-effective, but screening is appropriate for several risk groups. To prevent the transmission of the hepatitis C virus, the guidelines provides advise for the different risk group on how to prevent the spread of hepatitis C.

In 2005, BASL also formulated a guideline for the management of chronic hepatitis C in patients infected after substance abuse (Robaeys, Bottieau et al. 2005). The guideline was updated in 2007. Basically the guideline focuses on evidence-based recommendations for the diagnosis and management of chronic hepatitis C infection in substance users. The implementation of these guidelines should avoid the evolution of chronic hepatitis C virus (HCV) infection to end-stage liver disease, prevent liver transplantation in those patients and reduce the spread of the viral infection to other people. Although most parts of the guidelines consider the treatment of hepatitis C, the availability of drug use counselling and relapse prevention is stated to be important.

The Belgium Health Council provides recommendations about prevention of blood-borne diseases through, for example, transfusion, healthcare, dental care and the utilisation of badly disinfected equipments not used for medical care (http://www.health.belgium.be).
Harm reduction to prevent infectious diseases among drug users at risk

In 1995, the Belgian federal government formulated an action plan for illegal drugs, based on a health perspective and on the harm reduction philosophy. In 1998, a law was adopted allowing for needle exchange programmes. Today, such programmes (stationary, mobile or in pharmacies) are available across the country, except in the German community. In general, harm reduction projects are set up by NGOs and some are managed by the cities, and funded by the Federal Public Service Home Affairs.

In the French community, needle exchange programmes exist since 1994. In 2000, the Flemish community made the necessary legislative adaptations to implement needle exchange programmes, and in 2001 these were officially implemented. Since the start of these programmes they are still expanding in terms of sites to cover all geographical areas. In Belgium, access to safe injection equipment in prisons is not available. Also, in recent years, special emphasis has been given to counselling and testing for hepatitis C (see country overview at EMCDDA website: http://www.emcdda.europa.eu/publications/country-overviews/be).

In the Flemish community widely available syringe exchange sites exist such as in low threshold organisations, pharmacies, outreach worker etc.. Injection kits are distributed to drug users, including a syringe, sterile water and alcohol swabs. In the Flemish community a total of 642,897 syringes were distributed in 2008. The needle exchange program started to distribute aluminium foil to drug users in order to promote a switch from injecting to smoking. With regard to hepatitis C prevention the outpatient centre “Free Clinic” offers all clients blood screening on a regular basis (Reitox National Focal Point BELGIUM 2010).

In Belgium, there is a project on “Snowball Peers HIV & Hepatitis Prevention Operations”. Within the project peers are trained and given information and materials to recruit new activists among IDUs. In 2002 the project was also launched in prison (see: www.emcdda.europa.eu/html.cfm/index52006EN.html?by=262&value=828).

The Belgium Ministry of Health holds the opinion that attention should be focussed on drug users, as they are the main target group for prevention of infectious diseases. Thus, no specific actions are required to inform the general population. In February 2010, the Belgium Senate was requested to develop a National Action Plan which includes the prevention of blood-borne diseases (Robaeyts, Bottieau et al. 2005; Rigolle 2008).
4.3 Bulgaria

National prevalence of HCV among drug users

In Bulgaria, data on HCV prevalence among drug users is available for those drug users tested at the Laboratory of the National Centre for Addictions in Sofia. In 2008, 752 drug users had been tested by the National Centre and 57.5 % were found positive for hepatitis C. Among the tested drug users who are under the age of 25 the HCV infection rate was 61.6 % (Reitox National Focal Point BULGARIA 2010).

National drug policy on HCV prevention

Bulgaria’s second National Drug Strategy 2009-2013 was adopted in 2009 and is complemented by an action plan covering the same period. The National Anti-Drug Strategy has two major objectives which are demand reduction and supply reduction, and covers illicit drugs, psychoactive medicines and precursors.

In Bulgaria, drug prevention is focussed on health education in the school environment and combines the approaches of life skills and peer education. According to personal information of the Head of the Laboratory and Harm Reduction Department at the National Centre for Addiction in Bulgaria, Ms Violeta Bogdanova, there exists no specific policy or programme for the prevention of hepatitis C in the general population or for injecting drug users.

However, programmes to address high risk groups have been developed and implemented in Bulgaria. Furthermore in 2008 the National Centre for Addictions in Sofia has developed “guidelines for good practice in drug use harm reduction”.

Harm reduction to prevent infectious diseases among drug users at risk

In Bulgaria, substitution treatment with methadone and slow release morphine (Substitol) is offered to drug addicts. In 2006, the Council of Ministers launched a programme to improve methadone maintenance treatment aiming at the reduction of drug use and drug-related health risks. As a consequence, the number of specialised units delivering methadone substitution treatment has increased in recent years. Substitution treatment is ensured in the community substitution programmes in Sofia, Plovdiv and Varna.

With regard to the prevention of infectious diseases and drug-related overdoses the implementation of respective interventions is in line with the programme on ‘HIV/AIDS
Control and Prevention’ financed by the Global Fund for Fighting HIV/AIDS, Tuberculosis and Malaria. Mainly NGOs are involved in harm reduction, and for this purpose they address risk groups such as drug users of Roma origin, sex workers and IDUs. These risks groups are provided through outreach work, mobile units or drop-in centres with needle and syringe exchange, information materials on safe injecting, overdose and infectious diseases. In 2007, an estimated 735,000 syringes were distributed through specialised agencies and outreach programmes (see country overview at EMCDDA website: http://www.emcdda.europa.eu/publications/country-overviews/bu).

To prevent overdoses and blood-borne infectious diseases the project “Save a Life” has been implemented within the previous Action Plan of the National Strategy to Combat Drugs (2006–2008). The project was initiated as applying good practice and based on specialised programmes on overdose prevention adopted from other European countries.

In Bulgaria, counselling and anonymous and free testing for HIV/AIDS is provided in the bigger towns. Individuals infected with HIV, as well as AIDS patients, are treated in the specialised units for infectious diseases in Sofia, Plovdiv and Varna. Since 1993, vaccination against hepatitis B has been mandatory in Bulgaria for all new-born infants. However, since 2000 the Bulgarian Government does not provide vaccinations against hepatitis B to drug users. Only in Sofia, one NGO provides free vaccinations to IDUs, but the number of those that have been vaccinated is small.

With regard to hepatitis C the Head of the Laboratory and Harm Reduction Department at National Centre for Addiction in Bulgaria reported that there is only one specialised programme for the treatment of a hepatitis C infection. This programme is only accessible for HCV-infected people who have a health insurance.

4.4 Cyprus

National prevalence of HCV among drug users

In Cyprus, the prevalence of hepatitis C infections among intravenous drug users is rather low compared to other European countries. Based on the Indicator Protocol for Drug Related Infectious Diseases (DRID KI) the prevalence of hepatitis C infections among intravenous drug users was 29.2 % in 2008. The proportion of HCV infections among IDUs in the previous four years were in 34.3 % in 2007, in 29.6 % in 2006, 17.7 % in 2005 and in 9.1 % in 2004 (Reitox National Focal Point CYPRUS 2010).
National drug policy on HCV prevention

In Cyprus there is no national, policy or guideline specifically addressing HCV prevention. However, the National Strategy on Drugs (2009-2012), developed by the Cyprus Anti-Drugs Council, includes actions addressed to the prevention of hepatitis C. Accordingly, harm reduction is considered as one of the priorities, particularly with regard to reduce health problems such as HIV/AIDS and other infectious diseases (Reitox National Focal Point CYPRUS 2010).

Objectives of actions in the area of harm reduction are to facilitate access to harm reduction services, to improve early and effective prevention, and to limit harmful consequences of the use of drugs, as well as of social and other risks. The principle of harm reduction is based on the protection of the ‘right to health’ for individuals using addictive substances.

Harm reduction to prevent infectious diseases among drug users at risk

In Cyprus, harm reduction programmes are implemented within the framework of the so-called therapeutic continuum, covering the complete spectrum of psychosocial intervention, pharmaceutical treatment and social integration, and access to services for the prevention of HIV/AIDS, hepatitis, other infections diseases. Like other interventions harm reduction services have to follow the criteria for ‘good practice’.

The present National Strategy on Drugs emphasises the will to improve and enlarge availability of harm reduction services. In this respect, the following actions are mentioned:

- To facilitate the drug users’ access to clean equipment for the use of drugs, and to provide free syringes and information on safe use throughout the island
- To improve the quality of substitution treatment through inclusion of different substances for treatment and by the expansion of substitution treatment to other cities than Nicosia.
- To introduce and promote harm reduction practices in prison and in treatment facilities
- To monitor drug-related infectious diseases among IDUs more effectively facilitating testing for infectious diseases

4.5 Czech Republic

National prevalence of HCV among drug users

In the Czech Republic, data on the prevalence of hepatitis C infections among drug users are rather limited. One source for information are the prevalence rates reported by low-
threshold programmes, the other source are data on testing documented in the Register of Treatment Demands, which is in the responsibility of the Public Health Service.

In 2008, the prevalence of HCV among injecting drug users being tested in low-threshold programmes was approximately 12%. The rate of HCV infections in IDUs who were in contact with low-threshold programmes seems to decline slightly from 30-35 % in 2005 to less than 20 % in 2007, and to 12 % in 2008 (Reitox National Focal Point CZECH REPUBLIC 2010).

The prevalence of HCV among drug users reported to the Register of Treatment Demands is twice of the prevalence reported by low-threshold programmes. According to the Register of Treatment Demands in 2008 about 32 % of the drug users were infected with hepatitis C. The prevalence rate appears to be quite stable with 31-35 % in the years 2005 to 2007 (Reitox National Focal Point CZECH REPUBLIC 2010).

**National drug policy on HCV prevention**

The National Drug Policy Strategy 2005-2009 of the Czech Republic includes one pillar specifically focussed on the reduction of risks and health damages related to drug use. Respective activities in the area of harm reduction cover a range of objectives and interventions.

- To support and develop programmes that provide counselling and education on the prevention of infectious diseases and towards a safer lifestyle
- To educate drug users in safer ways of drug use through informative material
- To promote needles exchange programmes on a regional level
- To reduce the risks for specific groups of drug users (e.g. ethnic minorities, migrants, drug users in prisons) through analysis of the situation and development of appropriate actions

Furthermore it is intended to train professionals such as for instance staff of pharmacies in risk reduction for drug users. Low-threshold services and health institutes should contribute to the monitoring and prevention of infectious disease targeted at the injecting drug users.

In the Czech Republic a standard for the treatment of hepatitis among drug users has been developed in 2008 (Galsky, Husa et al. 2008). The standard is based on two other standards; one deals with the diagnosis and treatment of chronic hepatitis C and one is about diagnosis and therapy of hepatitis B. Both standards describe procedures recommended by the Czech Hepatology Association, the Czech Medical Association and the Czech Ministry of Health.
Harm reduction to prevent infectious diseases among drug users at risk

In Czech Republic harm reduction of drug-related health risks is mainly delivered by low-threshold facilities. In 2008, the nationwide network comprised 100 low-threshold facilities which – in the past three years – are visited by an increasing number of drug users. It is estimated that about 70 % of problem drug users are in contact with these facilities (Reitox National Focal Point CZECH REPUBLIC 2010).

The low-threshold centres and outreach programmes provide a variety of services to reduce drug-related harm including blood-borne diseases. Leaflets on the risk of infectious diseases and other health problems are distributed, and drug users are educated in safer drug use and safe sex. Furthermore there is a widely available needle exchange and opportunity for blood testing.

- Needle and syringe exchange programmes:

Sterile injecting equipment is distributed by low-threshold facilities, outreach work, pharmacies and vending machines. As a pilot project two vending machines have been installed in order to increase the availability of syringes and needles and to address a specific group of injecting drug users. Apart from clean injecting equipment the vending machines provide disinfectants, clean water etc. Low-threshold services also distribute aluminium foil for smoking heroin. In 2008 the number of syringes and needles distributed has further increased from 4.5 million in 2007 to 4.6 million in 2008 (Reitox National Focal Point CZECH REPUBLIC 2010).

For the safe disposal of used injecting equipment Safe Disposal Containers have been installed in selected places where a high level of injecting drug use occurs.

- Distribution of gelatine capsules as harm reduction intervention

Gelatine capsules provided to IDUs with the aim to reduce injecting drug use. The primary target group consists of individuals who inject pervitin, have damaged veins and look for alternative methods to inject drugs. Other target groups include recreational pervitin users who have no injecting experience, and socially stabilised drug users who are afraid of injecting drugs in certain circumstances (e.g. at work). Damaged veins and the motivation to reduce the frequency of drug injecting turned out to be the main reasons for the use of the capsules.

- Testing and vaccination

Quick tests and the related equipment for HCV antibody tests as well as HIV test were available at 40 low-threshold facilities in 2008. In the context with the HAV epidemic, drug
users were vaccinated against hepatitis A free of charge. Compared to the previous years the number of tests for HIV and HCV performed on drug users in low-threshold facilities almost doubled. The total of 40 low-threshold facilities carried out 862 tests in 2008 (Reitox National Focal Point CZECH REPUBLIC 2010).

4.6 Denmark

National prevalence of HCV among drug users

Based on various studies it is estimated that up to 75 % of the drug users are infected with hepatitis C. Of the drug users in Denmark about 35 % are infected with hepatitis B, and less than 5 % are infected with HIV. Among intravenous drug users the proportion of acute cases of HCV infections varies from 29 % to 85 % (Reitox National Focal Point DENMARK 2010).

National drug policy on HCV prevention

In 2006 the Danish governments and the reserve grant parties signed the Social Reserve Grants Agreement with the aim to limit drug-related harms for drug users, their relatives and the surrounding community. This agreement also includes decisions to strengthen interventions against hepatitis on a national scale. Accordingly the National Board of Health prepared an action plan for the prevention of HCV in 2007 (“National handlingsplan til forebyggelse af hepatitis C blandt stofmisbrugere”). This action plan recommends that the municipalities must ensure that the target group is a) systematically is offered prevention in terms of information and counselling for drug users on how to prevent blood-borne infections, and b) screening for hepatitis A, B, and C and HIV. Along with screening vaccination against hepatitis A and B and finally, referral to treatment should be provided (Reitox National Focal Point DENMARK 2010).

The objective of the action plan is to improve primary as well as secondary prevention. Screening and counselling have the function to raise awareness on risks of blood-borne diseases in the infected as well as the non-infected people. Treatment of those who are already infected will reduce the risk to transmitting the virus to non-infected persons. Target group of the action plan on HCV prevention are intravenous drug users admitted for treatment and drug users who have only injected drugs once.
Harm reduction to prevent infectious diseases among drug users at risk

In Denmark, harm reduction activities, such as outreach work, drop-in centres, syringe exchange programmes and social support at home, are part of the Social Welfare Act.

Syringe exchange, established in Denmark since 1986, is most often provided by pharmacies or through dispensing machines located in public sites. Some municipalities also distribute needles and syringes through shelters and boarding houses. On basis of the latest estimates (2005) about 910,000 syringes were distributed through needle exchange programmes (Reitox National Focal Point DENMARK 2010).

Opioid substitution treatment (OST) is widely offered to opiate addicts. The 2008 records of the National Board of Health show that the total number of persons receiving substitution treatment either in community or in Danish prison and probation services amount to approximately 8,050 (Reitox National Focal Point DENMARK 2010).

In line with the Social Reserve Grants Agreement in particular two initiatives have been recommended to the municipalities in order to combat infections with hepatitis among drug users:

- The municipalities must ensure that the drug services are organised in a way that preventive programmes are systematically provided to drug users. Independently from the diagnosis to be infected or not, drug users have to be offered 1) information and counselling on prevention of blood-borne infections, 2) screening for hepatitis (A, B and C) and HIV, 3) vaccination against hepatitis A and B, and 4) referral to treatment.
- The municipalities must ensure to provide a yearly report on the implementation of the action plan for each treatment institution used. The report is to facilitate the evaluation of the prevention and treatment programmes provided.

The national HCV policy, as stated in the action plan 2007, is directed to the control and reduction of infectious diseases among drug users. The implemented strategies of the action plan aim at the improvement of health education and blood awareness as a selective approach to address specific risk groups in the drug using population.

4.7 Estonia

National prevalence of HCV among drug users

In Estonia, the number of people with acute hepatitis C decreased considerably in the period from 1999 to 2007. Since then a slight increase in HCV infections is noticed. In 2008, 28 more cases of acute viral hepatitis C were registered (64 in total). Out of the per-
sons of whom the type of transmission was known, half belong to injecting drug users (Reitox National Focal Point ESTONIA 2010).

National drug policy on HCV prevention


Prevention as part of the present National Strategy on the Prevention of Drug Dependency is under the shared responsibility of the Ministry of Social Affairs and the Ministry of Education. National prevention is mostly based on county-specific HIV and drug prevention programmes and nationwide prevention campaigns. Those local action plans mostly contain youth activities (leisure, sport), activities related to raising students’ awareness and enhancing the competence of schoolteachers and county specialists.

With regard to HCV prevention, PhD Valentina Tefanova, senior researcher at Department of Virology of the National Institute for Health Development in Estonia, reported that there are no specific guidelines or standards or national policy on HCV prevention in Estonia.

However, Estonia is part of the UNODC funded project on "HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania". Purpose of the project (2007-2010) is to increase access availability, coverage and quality of the following interventions for IDUs: Needle and syringe programmes; Long-term pharmacotherapy of opioid dependence; Voluntary HIV counselling and testing; Targeted information, education and communication for IDUs.

Harm reduction to prevent infectious diseases among drug users at risk

Traditionally, drug treatment in Estonia is predominately provided through hospitals, which obtain a license for psychiatric services in order to provide inpatient and outpatient treatment for problem drug users. In recent years, treatment provision has gradually been taken over by specialised drug agencies, thus an increased availability of outpatient
treatment as well as of counselling and treatment options outside the psychiatric hospitals was noted. Moreover, drug service provision by NGOs has recently shown an increase.

Since 2004, the Tallinn City Government supports provision of substitution treatment for IDUs living in Tallinn. A new treatment centre for minors was opened in 2004 at Jõhvi Hospital in Ida Viru County, to provide drug-free treatment for children and young people aged 19 and younger. In 2008, an estimated total of 770 adult clients received methadone maintenance treatment through six treatment centres funded by the state (through the HIV/AIDS prevention strategy) and the Global Fund (Reitox National Focal Point ESTONIA 2010).

Harm reduction responses have increased in Estonia in recent years. This is illustrated by the fact that harm reduction measures were specifically mentioned in the new National Drug Strategy (2004-2012). NGOs are the most active institutions providing services for drug users, and they aim to reduce drug-related harm via activities such as counselling, HIV testing, and syringe and needle exchange. In 2002, the spread of HIV/AIDS was recognised in Estonia as a serious health problem, and in 2003 the Government began to fund syringe exchange within the framework of the national HIV/AIDS prevention programme. As a consequence, the coverage and quality of syringe exchange programmes has improved.

In 2008, more than 2 million syringes and 380,000 needles were distributed through a total of 36 syringe exchange points (stationary and mobile low-threshold services). These facilities registered 170,000 visits in 2008, with 4,045 visits by people using this service for their first time. 700,000 condoms were distributed to injecting drug users through these points (Reitox National Focal Point ESTONIA 2010).

Free testing and counselling is offered, amongst others at AIDS prevention centres in five Estonian cities. According to data from the Merimetsa Hospital Reference Laboratory in Tallinn, since the first reports of an HIV epidemic in Estonia in 2001, the number of tests carried out has increased continuously. In addition, 17 youth counselling centres offer free testing and counselling for people under the age of 18.

The prison population, sex workers and men who have sex with men are also seen as target groups and are provided with specific harm reduction services. In 2004, the NIHD drafted guidelines for HIV testing in order to improve the quality of services. In 2005, the Estonian Government approved the National HIV/AIDS Strategy 2006-2015.
4.8 Finland

*National prevalence of HCV among drug users*

In Finland, there is a register for infectious diseases. 1,144 new cases of hepatitis C infections were reported for the year 2008. In 55% of the cases the route of transmission was known, and in the majority of these cases (80%) the HCV infection was transmitted through intravenous drug use. Prevalence surveys of the National Institute for Health and Welfare (THL) in Finland indicate that the prevalence of HCV among intravenous drug users is 50-70%. According to the 2008 data of the drug treatment monitoring system, out of the IDU clients who were tested 63% (n=2,658) were positive for HCV (Reitox National Focal Point FINLAND 2010).

The prevalence differs by age group and duration of drug use. While hepatitis C infections decline in the 15–19 year-olds and slowly decrease in the 20–24 year-olds, the HCV infection rate among individuals with a continued intravenous drug use since ten years and registered in the drug treatment monitoring system is almost nearly 80% (see THL 2009: http://www.thl.fi/thl-client/pdfs/6223766d-ea1a-4a85-af48-339920ea9bb6).

However, according to the most recent national report to the EMCDDA, the number of new infections with HIV and hepatitis B and C among intravenous drug users has decreased since 2000. Based on the infectious diseases register infections with hepatitis C among IDUs have declined from 928 cases 2000 to 508 cases in 2008 (Reitox National Focal Point FINLAND 2010).

*National drug policy on HCV prevention*

In the national drug policy for 2008–2011 government stated its intention to ensure the basic actions related to drug treatment and harm reduction. A number of actions are related to the development and increased provision of drug treatment, following the aim to ensure access to services for all citizens. Harm reduction is ensured by treatment and in particular by health counselling. Interventions directed to reduce diseases and mental health problems will be increased (Reitox National Focal Point FINLAND 2010).

In Finland, there is a Communicable Disease Act. The amendment to this Act (1383/2003) declares that the municipal body responsible to combat infectious diseases has to ensure the provision of interventions for the prevention of infectious diseases, including health counselling for intravenous drug users and needle and syringe exchange. In addition,
there is a Decree (421/2004) recommending free vaccination programmes for hepatitis A and B directed to intravenous drug users, their sexual partners and individuals living in the same household.

At present, in Finland there are no guidelines for the prevention (or treatment) of infections with hepatitis C.

_Harm reduction to prevent infectious diseases among drug users at risk_

Current harm reduction responses in Finland include outreach work and health counselling centres. As the health counselling centres play a major role in provision of harm reduction to drug users, the National Public Health Institute of Finland has conducted an evaluation study on the effectiveness of these centres. According to the study, published in 2008, the services of health counselling centres made remarkable contributions to the prevention of infections with HIV, hepatitis A and B and, to some extent, hepatitis C among intravenous drug users. More than half of the health centres reported that they provide health counselling related to drug use (56 %), information on infectious diseases (51 %), and about one third stated to provide interventions for the reduction of the risks related to drug injection (36%) (Malin-Kaartinen and Rönkä 2008).

- Health counselling centres

Health counselling centres are low-threshold facilities offering, referral to treatment, case management, harm reduction such as information on drug-related diseases and risks such as overdoses, testing for infectious diseases and vaccinations and small-scale healthcare to problem drug users. Since 1997, such centres have been established throughout the country. In 2007, there were 38 health counselling centres, and it is estimated that they reach 60–80 % of the problem drug users (Reitox National Focal Point FINLAND 2010).

- Needle and syringe exchange

Needles and syringes are exchanged by the health counselling centres. In 2007, the turnover of exchanges syringes was more than 2.6 million. Needle and syringes can also be purchased in most of the pharmacies in Finland (see country overview at EMCDDA website: http://www.emcdda.europa.eu/publications/country-overviews/fi).

- Testing for HIV and hepatitis

Testing for hepatitis is in four out of five health counselling centres. According to the operating statistics from 2006, health counselling centres carried out a total of 1,409 HIV tests and 582 hepatitis C tests.
Vaccination

Based on information of the national drug treatment about two-thirds of the clients who have ever injected drugs had received at least one of the vaccine doses for hepatitis B. A total of 51% had received all three vaccine doses. Drug users are offered free hepatitis A and B vaccination in nearly half of the health counselling centres (Malin-Kaartinen and Rönkä 2008).

Harm reduction in prison

In Finland, there are no sterile needles and syringes available for drug using inmates. At entry they receive disinfectant for cleaning needles. Except from this, inmates are offered screening for HIV and hepatitis B and C, low-threshold health counselling and peer support. Peer support for drug using inmates has been established by the project TERVE. Within the project inmates who had used drugs or were still using drugs were trained in harm-reducing methods.

4.9 France

National prevalence of HCV among drug users

Data on hepatitis C among drug users is from 2006 and based on two different sources: first the PRELUD “bio” survey and second the Ena-CAARUD national survey.

In 2006, the PRELUD "bio" survey reported a prevalence of hepatitis C among drug users of 32%. Among drug injectors, the estimated prevalence rises to 42%. In the same survey an increase in the screening frequency among younger users has been observed. In drug users below the age of 25 the proportion of those who never participated in screening decreased from 39% in 2003 to 25% in 2006. The national survey ENa-CAARUD, carried out for the first time in late 2006, provides information on the HIV and HCV infection status declared by the drug users who were interviewed in the participating centres. In 2006, the majority of drug users (81%) made use of HCV testing, and among these 35% were infected with HCV (Reitox National Focal Point FRANCE 2007).

The latest data on HCV prevalence is from the RECAP survey, which is based on basis clients treated in the available 210 Outpatients Specialised Drug Addiction Treatment Centres. According to the RECAP data for 2007, the prevalence of hepatitis C among patients having injected and being tested is 51% (Reitox National Focal Point FRANCE 2010).
National drug policy on HCV prevention

According to the national reports submitted to the EMCDDA the policy on risk reduction in France is defined as all the measures implemented to prevent infections with HIV and hepatitis viruses, and also the problems and complications resulting from drug use.

The five-year public health law (2004-2008) on alcohol, tobacco and illicit drugs has defined harm reduction policy for drug users as part of public health. The law includes benchmarks related to infectious diseases. One target of the law is to reduce deaths attributable to chronic hepatitis by 30 %, and to reduce the number of patients with chronic hepatitis from 10-20 % to 7-14 % by 2008. Furthermore the importance is stated that risk reduction programmes have to be consolidated in order to deal with the increasing prevalence of hepatitis C among drug users. In this respect a decree has been issued by the Health Ministry which defines the framework and procedures of low-threshold facilities (Ministère des Solidarités; de la Santé et de la Famille 2005).

In addition there was a seminar in 2004 arranged by the National Institute for Health, Education, and Prevention aiming at the identification of the most efficient approaches to reduce the incidence of hepatitis among the IDU population in France.

In France a programme to control the spread of hepatitis B and C has been launched for the period 2002-2005. The main objectives of the plan were to implement action for reducing hepatitis transmissions, improving screening and treatment, and intensifying clinical research, monitoring and evaluation. Prevention activities addressing infections through sniffing is controversially discussed in France. However, several associations are involved with this issue despite little support from the State. A following national plan to combat hepatitis B and C (2009-2012) was launched in February 2009 by the Ministry of Education. The 2009-2012 hepatitis plan seeks to "reduce morbidity and mortality levels related to chronic viral hepatitis B and C, through a combination of improved prevention and easier access to screening while improving access to effective treatment and financing". Key objectives of this plan are to increase screening and awareness for infections from 57 % to 80 % for hepatitis C and from 45% to 65% for hepatitis B. A further key objective is to establish 100 % refund of screening costs for hepatitis B (compared to the current level of 65%) (Reitox National Focal Point FRANCE 2010).

The French law does not allow the distribution of injecting equipment in prison, but since 1996 the Penitentiary Administration allowed free and systematic distribution of bleach to detainees.
**Harm reduction to prevent infectious diseases among drug users at risk**

Harm reduction services include basically drop-in centres, information and education on safer injecting and safer sex, condom distribution, substitution treatment (mostly with buprenorphine but also methadone), access to sterile injection equipment, and screening for infectious diseases.

A major objective is to facilitate access for high-risk populations to sterile needles and syringes and to screening. In France, there is a free sale of syringes in pharmacies, and there are dispensing machines delivering Stéribox® injection kits. Injecting equipment is also distributed by community needle and syringe programmes.

French Family Planning Centres and community Health Associations provide services related to HIV, hepatitis, and STD's for pregnant women, sex workers, female drug addicts, homeless women, migrants and heterosexual multipartnership environment. In prisons, all detainees are offered medical consultation provided by an outpatient consultation and treatment unit (UCSA). This unit offers screening for tuberculosis, voluntary and confidential HIV testing and, recently, screening for hepatitis C and hepatitis B vaccination.

NGOs active in harm reduction emphasise the importance to increase the availability of harm reduction and to improve respective services. Recommendations are made as to information, training, screening, and cross-disciplinary care. For instance, it is suggested to make IDUs partners in developing and evaluating actions, tools, and messages, and to adjust actions, tools, and messages to the particularities of drug using subgroups.

**4.10 Germany**

**National prevalence of HCV among drug users**

In Germany, the Infectious Diseases Control Law from the 1st January 2001 required that data on infectious diseases, including HIV and viral hepatitis, are to be reported to the Robert Koch-Institute (RKI, see: www.rki.de). Since introduction of this law the possible routes of transmission of hepatitis B and C are also documented. Furthermore there is a regular statistical report on treatment centres for substance use disorders, and since 2007 this report also includes data on the HBV- and HCV-status of the treatment clients.

In the year 2008, data on 4,456 cases of hepatitis C transmission were available, which is 72 % of the new HCV infections among the general population. Intravenous drug use
accounted for 36 % of the hepatitis C cases (1,607 cases). Among men between the age of 20-29 intravenous drug use was reported in 73 % of the HCV infections - related known routes of transmission in men of this age group. In 2008, data from outpatient drug treatment services show the following: among opiate users 54.8 % were positive for HCV, and in clients with any other drug problem the rate of infection with HCV was 43.8 %. In comparison with the previous year the HCV prevalence has slightly declined (Reitox National Focal Point GERMANY 2010).

**National drug policy on HCV prevention**

In Germany, the Action Plan on Drugs and Addiction was adopted in June 2003, and continues to present the framework for current “addiction policy”. In the past ten years the German drug policy shifted from exclusively focussing on illicit drugs to the coverage of a range of addictive substances. Since a few years the policy on substance use disorders has developed as follows (Reitox National Focal Point GERMANY 2010):

- Covering disorders resulting from licit psychotropic substances (alcohol, tobacco) as well as from illicit drugs, and
- non-substance-related disorders such as pathological gambling.
- Move of the political interest from the focus on substance-related addiction to present focus on risky and harmful use, reflecting a comprehensive understanding of health policy.

With regard to the prevention of hepatitis C among drug users, there is no specific policy in Germany. However, experts have developed two guidelines on the treatment of hepatitis C. The first one was a result of a consensus conference held in 2006. The German Society for Addiction Medicine (Deutschen Gesellschaft für Suchtmedizin, DGS e.V.) passed a guideline for the treatment of chronic hepatitis C in injecting substance users, which clearly recommends the treatment of hepatitis C in opioid addicts, in particular if they are in substitution treatment (Backmund, Hinrichsen et al. 2006). The second guideline was published in 2010 and is an update of a former guideline on prevention, diagnosis and treatment of the hepatitis C virus (Sarrazin, Berg et al. 2010). The high quality guideline is based upon a consensus of German, Austrian and Swiss medical associations and patient organisations, following the criteria for consensus processes of the Association of the Scientific Medical Societies in Germany (AWMF). The consensus group consisted of 7 different working groups, with one working group dealing with prevention and monitoring of HCV in drug users. The guideline sets standards for prevention, diagnosis and evidence-based antiviral therapies. It is directed to physicians, nurses, staff of the health system linked to care for patients with a HCV infection.
Harm reduction is one of the four pillars of the national addiction policy. The major aim of harm reduction is to reduce mortality and morbidity, and related interventions are low-threshold services, pharmacologically assisted treatment, syringe exchange programmes, emergency shelters, drug consumption rooms, safer use campaigns, distribution of condoms and also vaccination campaigns for hepatitis A and B. In Germany, there are about 400 institutions offering harm reduction services, most of them are financed by the municipalities.

- Prevention of drug-related infection diseases

The prevention of drug-related infectious diseases is basically provided in low-threshold facilities. The facilities distribute information on risks for blood-borne virus infections, injecting equipment and further material for safer-use. According to the most recent information, at least 25 of the 1,000 nationwide outpatient counselling facilities and low-threshold services in Germany offer syringe exchange programmes. In addition outreach work is one important approach in harm-reduction.

- Drug consumption rooms

On basis of the national law the governments of the Federal States can pass a special regulation allowing drug consumption rooms to be implemented. At present only 6 out of 16 Federal States made use of the law and run drug consumption rooms. In the 6 Federal States a total 25 drug consumption rooms exist. These facilities allow injecting as well as smoking and sniffing of drugs (see: http://www.konsumraum.de/).

- Pilot project on hepatitis C prevention for drug users

For the period from October 2008 to September 2010 the German Ministry of Health funds a pilot project on hepatitis C prevention. The project is carried out by the Berlin counselling facility “Fixpunkt e.V.” Main objective of the project is to approach HCV-negative drug users at an early stage of their “drug career” and to develop hepatitis C prevention measures which on the one hand inform on the risks of HCV infection and on the other hand prevent infection with hepatitis C (for further information see: www.fixpunkte.org). With funds of the Federal State Berlin the pilot project is evaluated by the Centre for Interdisciplinary Addiction Research in Hamburg.

- Treatment of hepatitis C

There had been a representative longitudinal study (COBRA-study) carried out among 2,414 opioid addicts in antiviral treatment during their substitution treatment. The study had to important results (Schäfer, Wittchen et al. 2009): First of all it showed that two
thirds of the patients in substitution treatment were infected with hepatitis C, but only about 10% received antiviral treatment. Secondly, the interferon therapy HCV-infected patients did not affect the reliability and effectiveness of substitution therapy.

### 4.11 Greece

**National prevalence of HCV among drug users**

As far as the data of 2008 are concerned HCV infection rates in the IDU population in Greece range between 44.2% and 55.5%, depending on the treatment programme and the clients’ different profiles (Reitox National Focal Point GREECE 2010). Clients of drug-free treatment programmes are usually younger and have a less severe drug abuse history, and thus tend to have lower HCV infection rates. More specifically, the data of the 2010 national report to the EMCDDA indicate that HCV infection rates in IDUs attending substitution programmes are 60.9%, in clients of low-threshold services 77.5%, and in clients of drug-free programmes 44.7%. With regard to gender, there is no difference between female and male IDUs in HCV infection rates (55.8% in male and 52.5% in female). Although hepatitis C infection rates in IDUs have remained high over time, in 2008 a downward trend is observed compared to 2006.

**National drug policy on HCV prevention**

In Greece, the national policy for the prevention of hepatitis C is defined in the National Action Plan (2008-2012) for the prevention of infectious diseases (Ministry of Health and Social Solidarity 2008a). The strategy’s principle components are: primary prevention, early detection and surveillance, systematic analysis of data for policy making, assessment of structures, and health policy proposals and effective treatment. The Action Plan highlights the role of European Community and World Health Organization (WHO) in preventing and controlling HCV.

In addition, the National Action Plan on Drugs 2008-2012 includes actions directed at HCV prevention (Ministry of Health and Social Solidarity 2008b). Amongst others, the Action Plan promotes prevention and awareness programmes to vulnerable groups (HIV/AIDS positive individuals, sex workers, prisoners) in order to reduce the incidence and outbreaks of HIV/AIDS, hepatitis B and C and other infectious diseases. Main objectives of the actions related to the prevention of infectious diseases are:
Extensive delivery of information on early intervention services, therapy, rehabilitation in order to increase accessibility

Awareness of the staff for addressing drug addiction and infectious diseases

Strengthening of local support networks and mobilisation of volunteers to promote prevention

Support for harm reduction practices (safer use, needle exchange programmes) through distribution of informative material and outreach work

_Harm reduction to prevent infectious diseases among drug users at risk_

In Greece, the prevention and control of HCV is mainly carried out by Public Health Services and national organisations for infectious diseases. In addition, non-governmental organisations play an important role in the respective actions and interventions. The national services for the prevention and control of HCV are responsible for epidemiological surveillance for monitoring infectious diseases and evaluation of the effectiveness of prevention and medical care. Furthermore the national services for prevention of hepatitis C are offering screening for blood-borne diseases and medical management of hepatitis infections. The medical management is to limit the burden from chronic hepatitis and to improve the quality of life of those chronically infected with HBV and HCV. The prevention services also provide education and information on risks of infectious diseases to health care professionals and drug users.

Available low-threshold counselling services offer a range of harm-reduction interventions to drug users. These are:

- Education and information

Low-threshold counselling units distribute printed information material to drug users on how to prevent infectious diseases. They provide advice and training on safer use and safer injecting. Seminars on health education and information are organised to provide training to prisoners and drug users in the prevention of infectious diseases. Some low-threshold services in Greece involve former or current drug users as peer educators who train drug users in the prevention of infectious diseases.

The national organisations for infectious diseases provide education of drug users in learning about the risk of HCV transmission and the need testing. Health care and public health professionals are educated to identify persons at risk for HCV infection and to ensure appropriate counselling, diagnosis, medical management, and treatment.

- Outreach work
Outreach work aims at the prevention of risk behaviour for individuals identified as being at risk for HCV infection. Respective services approach in particular intravenous drug users in order to promote safer use practices, testing and to motivate for the participation in training programmes on the prevention of infectious diseases. In Greece there are 6 outreach work programmes.

- Distribution of needle and syringe and condoms

In Greece, there are no more than three needle exchange programmes, with two of them being mobile units. There are also three condom-only distribution programmes. In 2008, these three needle exchange programme had contacts to 10,192 drug users and distributed 55,109 needles and syringes (Reitox National Focal Point GREECE 2010).

4.12 Hungary

National prevalence of HCV among drug users

On basis of the screening results of the National Centre for Epidemiology the prevalence of hepatitis C among injecting drug users was approximately 22.6 % in 2008. Compared to the prevalence of HCV among IDUs in the last years there is a slight decrease of the HCV infection from 2007 (25.7 %) to 2008 (Reitox National Focal Point HUNGARY 2010).

The data for 2008 provide a detailed breakdown of the HCV infections among IDUs by age group (see the table below).

2008 breakdown of the HCV infected IDUs by age group and gender

<table>
<thead>
<tr>
<th>Age group</th>
<th>Gender</th>
<th>IDUs being positive for HCV antibodies (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 25 years</td>
<td>Male</td>
<td>19.4</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>20.5</td>
</tr>
<tr>
<td>25-34 years</td>
<td>Male</td>
<td>20.9</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>22.6</td>
</tr>
<tr>
<td>&gt; 34 years</td>
<td>Male</td>
<td>23.9</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>35.7</td>
</tr>
<tr>
<td>Total</td>
<td>Male</td>
<td>21.5</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>25.4</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>22.6</td>
</tr>
</tbody>
</table>
National drug policy on HCV prevention

The Hungarian National Strategy for Tackling the Drugs Problem 2010–2018 determines the national drug policy in the four pillars prevention, treatment, supply reduction, and harm reduction. Main objectives of the National Strategy are to improve the health status of the society, to increase social safety, and to reduce the rate of drug consumption, the harms, risks and damages of the use of legal and illegal drugs.

In Hungary there is no specific guideline or standard on the prevention of hepatitis C. However, a guideline from the EMCDDA on “provider initiated screening and counselling among intravenous drug users on infectious diseases” (Blystad and Wiessing 2009) has been summarised in Hungarian language and adapted to the needs of the Hungarian population. The guideline includes recommendations for appropriate interventions to reduce the risks related to a specific health problem or target group, and to improve the prevention and control of infectious diseases.

Harm reduction to prevent infectious diseases among drug users at risk

In Hungary, harm reduction services provided for the prevention of drug related infectious diseases mainly consist in needle and syringe exchange and in testing combined with counselling (Reitox National Focal Point HUNGARY 2010).

- Needles and syringe exchange

In 2008, there were 10 fixed needle exchange service and two mobile needle exchange services. In addition drug users can obtain sterile injecting equipment from a few vending machines. Compared to the previous year the number of distributed syringes increased significantly by 54 %. Through the existing twelve fixed and mobile NSP programmes and the vending machines a total of 298,098 syringes were distributed to 1,944 clients in 2008.

- Outreach programmes

Outreach programmes aim at accessing hidden IDUs and to make needle/syringe exchange available to them. In 2008, in Budapest and outside altogether 11 outreach programmes existed which distributed a total number of 19,993 syringes.

- Counselling and screening

The National Centre for Epidemiology organised a national screening programme for HIV and hepatitis B and C from 15 October and 31 December in 2008. During this period 590 IDUs undertook blood testing and they were informed about their test results by the 18 participating specialised outpatient treatment centres and needle/syringe programmes. In
case of a positive result, persons infected with HCV attend counselling to be informed on antiviral treatment. Furthermore they are provided with information about strategies to prevent the spread of the HCV infection.

In 2007 a hepatitis C screening campaign was implemented in detention facilities, giving prisoners the opportunity to take part in the screening voluntarily. During this campaign blood samples were also tested for HIV and HBV

- Vaccination for hepatitis B

Clients participating in the NSP programme of the Drug Prevention Foundation are offered vaccination against hepatitis B virus free of charge. Due to the national vaccination programme, all individuals who were born after 1985 had been vaccinated at the age of 14.

4.13 Ireland

National prevalence of HCV among drug users

In Ireland, the HPSC (Health Protection Surveillance Centre) is the national specialist agency for the surveillance of communicable diseases. The centre reported that there were 1,537 newly diagnosed cases of hepatitis C in 2008, compared to 1,128 cases in 2004. Of those hepatitis C cases in 2008 with a reported risk factor, the majority were related to injecting drug use. In 77 % injecting drug use was the main risk factor for the infection with HCV. Among the HCV-positive IDUs in 2008 71 % were male and 62 % were under 35 years old (Reitox National Focal Point IRELAND 2009).

National drug policy on HCV prevention

The strategy to deal with hepatitis C was established by a working group established by the HSE (Health Executive Service) in 2007. The national task of the 2007 initiative was to examine how Ireland can best respond to hepatitis C in the areas of surveillance, education and treatment. The group has completed its report in 2009 which includes prioritised recommendations (Reitox National Focal Point IRELAND 2009).

In September 2009 the National Drug Strategy 2009–2016 has been launched. In consideration of the reviewed progress of the previous Drug Strategy (2001–2008) a tiered or graduated approach to prevention and education measures related to drugs and alcohol is intended. In the present National Drug Strategy (2009–2016) the treatment of drug users with hepatitis C is specifically mentioned for the first time.
With regard to existing guidelines, in Ireland there are two guidelines addressing blood-borne diseases. The first guideline was published by the Department of Health and Children in 2005 with the title: The prevention of transmission of blood-borne diseases in the health-care setting. This guideline is a code of practice underlining the approach to patient and health care worker protection from blood-borne viruses. Hepatitis C prevention should be based on the screening of all health-care workers who undertake EPPs for antibodies to HCV and, if positive, proceeding to PCR testing for hepatitis C RNA. According to the guideline this screening process should be introduced on an incremental basis (Department of Health and Children 2005). The second guideline is from the Eastern regional Health Authority and focuses on management of hepatitis C among drug users attending general practice. This guideline contains advice for GP’s on all aspects of care of patients at risk of HCV, including general and preventive care (Barry, Bourke et al. 2004).

_Harm reduction to prevent infectious diseases among drug users at risk_

Needle and syringe exchange services were first provided in Ireland in 1989, when five exchanges were established. Now there are 34 exchange services in the country, operating three models of service: fixed-site exchanges, home visit exchanges, and exchanges in public locations. Distribution of needles and syringes through pharmacy, vending machine or in prison is not available in Ireland. Along with the syringe exchange several organisations provide information about safe drug use, safe sex and treatment options to drug users (see: [www.emcdda.europa.eu/html.cfm/index52006EN.html?by=262&value=828](http://www.emcdda.europa.eu/html.cfm/index52006EN.html?by=262&value=828)).

In terms of harm reduction hepatitis B vaccine is recommended for several high-risk groups. Prisoners and injecting drug users are two of the high-risk groups (see country overview at EMCDDA website: [http://www.emcdda.europa.eu/publications/country-overviews/ie](http://www.emcdda.europa.eu/publications/country-overviews/ie)). According to the latest report only few drug users infected with the hepatitis C virus receive effective antiviral therapy. A pilot study of supervised antiviral treatment in a community non-residential drug treatment facility demonstrated that effective treatment retention can be improved for this patient group by shared care with drug treatment services, without the need for significant increases in resources (Reitox National Focal Point IRELAND 2009).
4.14 Italy

National prevalence of HCV among drug users

The current national report provides information on the prevalence of hepatitis C in drug users attending treatment at Ser.T in the course of 2008. Out of 59,810 clients already in treatment 51.9% were tested for hepatitis C, among the 11,298 new clients 36.2% were tested. In consideration of the HCV testing rate, 65.4% of the drug users already in treatment, and 25.6% of the new clients were positive for hepatitis C. In the last 11 years the HCV infection rate declined by 9% from 67% in 1997 to 58% in 2008 (Reitox National Focal Point ITALY 2010).

National drug policy on HCV prevention

In Italy, there is no specific policy on hepatitis C prevention for drug users. Some harm reduction interventions have been developed, but their relation to blood-borne diseases is not clearly mentioned.

The Italian Association for the Study of the Liver recently published “recommendations for the prevention, diagnosis and treatment of hepatitis B and C” (Babudieri, Barbarini et al. 2010). These recommendations specifically cover special at-risk populations such as migrants, drug users and prisoners. At level of interventions the following is recommended: testing for hepatitis C, vaccination for hepatitis A and B, health education/health promotion, risk assessment, risk awareness for tattooing and piercing.

Harm reduction to prevent infectious diseases among drug users at risk

With regard to harm reduction available in Italy there are outreach services, mobile treatment units, low threshold services and drop in centres. Drug users are offered substitution and maintenance treatment, counselling, needle and syringe exchange programmes including machines providing injecting equipment, vaccination for hepatitis B, and condoms. Furthermore information materials on risks of drug injecting drug-related infectious diseases are distributed.

There is peer education, and there are peer groups operating in at-risk contexts. Information and education on safer injecting and safer sex are provided. The treatment centres Ser.T offer screening for infectious diseases and refer drug users infected with HCV to treatment for hepatitis C.
However, in the past 17 years (1991 to 2008) a steadily declining proportion of drug users in drug treatment were screened for infectious diseases related to the use of illicit drugs (Reitox National Focal Point ITALY 2010).

4.15 Latvia

National prevalence of HCV among drug users

Among intravenous drug users there is a significant increase in the incidence of hepatitis C. While the incidence of hepatitis B has remained stable since 2006, the incidence of hepatitis C has increased by almost 50 % since 2006. In the most recent national report it is emphasised that there might be many “hidden” drug users in Latvia suffering from hepatitis B and from hepatitis C since testing for other infections than HIV is only available for a charge (Reitox National Focal Point LATVIA 2010).

According to EMCDDA the HCV prevalence among drug users in Riga was 74.4 % (see Table INF-111 from the EMCDDA Statistical Bulletin 2010). In 2007, the prevalence of infections with hepatitis C among young drug users (under age of 25) in Riga was 59 % (see Table INF-112 from the EMCDDA Statistical Bulletin 2010).

National drug policy on HCV prevention

Latvia’s current drug policy is the National Drug Programme 2005–2008. This programme focuses on illicit substances, and aims at the reduction of drug demand and supply, reduction drug-related infectious diseases, mortality and crime. The national programme covers four fields of action: international collaboration and strengthening the legal basis for drugs control, demand reduction, supply reduction, data collection/analysis and evaluation of information. The programme also lists actions and responsibilities to be carried out.

The National Drug Programme (2005–2008) was evaluated in 2009 and, during that year, the implementation of a transitory Action Plan on drugs was foreseen. However, this plan was not adopted. Instead the Drug Control and Drug Addiction Restriction Coordination Council decided to continue the Programme in 2009 in order complete the tasks which have not be implemented or only partly implemented.

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4 Table INF-111 is available at http://www.emcdda.europa.eu/stats10/inftab111
5 Table INF-112 is available at http://www.emcdda.europa.eu/stats10/inftab111
The Ministry of Health and the Ministry of Science and Education are the main authorities responsible for drug prevention activities in Latvia. The Ministry of Science and Education is responsible for the introduction of drug prevention in school programmes and in youth programmes outside the school. Health classes that also address substance use are integrated into the basic national curriculum. There are several institutions in Latvia undertaking prevention activities, however, they are focused on the capital Riga and surroundings, the majority of activities are mass media campaigns, and often activities in the field of dependence are integrated into broader health promotion activities. The implementation of selective prevention is generally weak and a unified approach to the implementation of universal and selective prevention activities is lacking. Due to lack of funding and capacity, only few outcome evaluations are carried out.

Latvia is part of the UNODC funded project on "HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania". Purpose of the project (2007-2010) is to increase access availability, coverage and quality of the following interventions for IDUs: Needle and syringe programmes; long-term pharmacotherapy of opioid dependence; voluntary HIV counselling and testing; targeted information, education and communication for IDUs.

**Harm reduction to prevent infectious diseases among drug users at risk**

In Latvia, the national coordination body for drug treatment is the Riga Centre of Psychiatry and Addiction Disorders, which is responsible for delivery, accreditation, monitoring and evaluation of drug treatment. Drug treatment is mainly delivered by the Riga Centre of Psychiatry and Addiction Disorders, together with hospitals which operate under the supervision of the Ministry of Health and are funded by the state budget of the Health Compulsory Insurance State Agency. Drug treatment is also delivered by private, profit-making organisations. Drug treatment services are available in outpatient and inpatient clinics, and in addiction units at general medical treatment institutions. Increasingly, different private organisations are providing drug treatment services, both on an outpatient and inpatient basis.

Harm reduction programmes in Latvia consist of opiate substitution programmes, needle and syringe exchange programmes, and the dissemination of information on infectious diseases among high-risk groups. Due to the participation in the UNODC grant programme harm reduction could be improved in Latvia. Thus, eight low-threshold programmes were able to develop or expand existing services addressing the needs of injecting drug users. These services offer needle and syringe exchange or distribution,
condom distribution, rapid HIV testing, hepatitis testing, and peer education (Stuikyte 2008).

Since 1996, the Riga Centre of Psychiatry and Addiction Disorders has been providing methadone maintenance treatment, and since 2003, maintenance treatment has been offered using buprenorphine. In 2007, the total number of clients in substitution treatment was 230; 100 received methadone and 130 buprenorphine.

One national priority in response to drug-related infections is to support individual counselling on risks of infectious diseases. The AIDS and STD Prevention Centre administer 13 consulting centres in the largest Latvian municipalities. Needle and syringe exchange programmes in Latvia are part of the state HIV prevention programme, which was formally defined in 1997 and became operational in 1999. In 2007, about 126,500 syringes were distributed through 22 fixed and mobile needle and syringe exchange points, which were operational in 12 Latvian cities (see country overview at EMCDDA website: http://www.emcdda.europa.eu/publications/country-overviews/lv). The numbers of needles and condoms distributed increased significantly as a result of the UNODC grants (Stuikyte 2008).

4.16 Lithuania

_National prevalence of HCV among drug users_

Prevalence rates on virus infections are available for drug users treated at the “Centres for Addictive Disorders” which operate in a number of Lithuanian cities. Of the drug users in treatment 71 % are infected with HCV, 11.9 % are HIV-positive and 8.9 % are infected with hepatitis B in 2008 (Reitox National Focal Point LITHUANIA 2010). According to the EMCDDA data, in 2006 the prevalence of hepatitis C among drug users ranges from 70.3 % in Vilnius to 93.7 % in Alytus (see Table INF-111 from the EMCDDA Statistical Bulletin 2010). Among young drug users (up to 25 years) the prevalence of hepatitis C is even higher and is about 78.3 % in Alytus in 2004 (see Table INF-112 from the EMCDDA Statistical Bulletin 2010). The Lithuanian AIDS Centre conducted a survey on the prevalence of HIV and other infections among IDUs (Reitox National Focal Point LITHUANIA 2010). From October 2007 to January 2008, questionnaires were conducted with 400 active injecting drug users

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6 Table INF-111 is available at http://www.emcdda.europa.eu/stats10/inftab111
7 Table INF-112 is available at http://www.emcdda.europa.eu/stats10/inftab112
in Vilnius. 95 % of the respondents are infected with hepatitis C. Preliminary findings show that almost 6 % of the respondents made their first drug injection with a syringe or needle which was already used by someone else. 68 % (n=270) of the respondents answered that within the last 6 months they injected drugs taking solution into their syringe from a common drug mixing container in which another person had dipped his/her syringe. This risk behaviour may explain the considerably high proportion of HCV among IDUs in Lithuania.

National drug policy on HCV prevention

Lithuania’s national policy on drug control and prevention of drug addiction is established in the National Strategy on Drug Addiction Prevention and Control 2004–2008 and in the National Program on Drug Control and Prevention of Drug Addiction 2004–2008. Both drug policy documents ended in 2008. They were to be replaced by a new National Program on Drug Control and Prevention of Drug Addiction 2009-2016 that prioritises four areas: demand reduction, among children and youth in particular; supply reduction; cooperation and coordination; and scientific research. Key objectives of the programme are to reduce the use of illicit drugs and the supply of narcotic drugs and psychotropic substances. This new programme is still in its adoption phase in 2010.

The Lithuanian drug policy strategy prioritises prevention of drug use in the family, among children and youths. The drug prevention projects executed in Lithuania in 2008 focused mainly on universal and selective prevention in local communities and schools, aiming at the protection of young people against drug use.

Along with Estonia and Latvia Lithuania is part of the UNODC funded project on "HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania". Purpose of the project (2007-2010) is to increase access availability, coverage and quality of the following interventions for IDUs: needle and syringe programmes; long-term pharmacotherapy of opioid dependence; voluntary HIV counselling and testing; targeted information, education and communication for IDUs.

Within the UNODC funding a number of actions and research projects have been implemented addressing health issues of IDUs. One task was directed to increase access to needle and syringe programmes in health centres, social services in municipalities etc. Accordingly a study has been carried out in July2008 to October 2008 among pharmacists and injecting drug users in order to investigate provision of and access to sterile injecting equipment.
Harm reduction to prevent infectious diseases among drug users at risk

Lithuania is among the countries with limited options of substitution treatment, and high requirements are applied to it. In Lithuania, methadone treatment of opioid addiction was started in September 1995. Prescription of substitution treatment and its implementation procedures are regulated by decrees of the Minister of Health. The Decree of the Minister of Health (2007) allowed to use methadone and buprenorphine for substitution treatment. In addition a composite pharmaceutical containing buprenorphine and naloxone was registered for drug treatment. During 2008, 872 opiate addicts were in substitution treatment (Reitox National Focal Point LITHUANIA 2010).

In 2008, 14 harm reduction services units (including syringe and needle exchange) were available in Lithuania. The existing low threshold services documented 56,548 in 2008 (43,856 in 2007). 5,942 drug users made regularly use of the low-threshold services in 2008 (3,339 in 2007) (Reitox National Focal Point LITHUANIA 2010).

The legal basis for the implementation of syringe/needle exchange programs was established in 2006 by the Minister of Health of the Republic of Lithuania. The respective legislation establishes the following mandatory services for injecting drug users: syringe/needle exchange, distribution of disinfecting tools, distribution of condoms, health education to reduce risk behaviour, providing of information and counselling.

In 2008, services distributed to drug users 313,894 needles (2007: 226,674), 238,745 syringes (2007: 187,227), and 42,848 condoms (Reitox National Focal Point LITHUANIA 2010). Findings from the above mentioned survey of the Lithuanian AIDS Centre show that within the last 4 weeks 54 % respondents bought their needles and syringes in pharmacies, 58 % received their injecting equipment form a stationary needle/syringe exchange programme and 56 % from a street worker or a mobile needle/syringe exchange unit.

4.17 Luxemburg

National prevalence of HCV among drug users

The prevalence of hepatitis B and HIV among problem drug users remains stable while the prevalence of hepatitis C increases in recent years, especially in prison settings (Reitox National Focal Point LUXEMBOURG 2010). Luxembourg registers acute and chronic HCV infections. 395 cases of HCV infections were reported in 2004. In 44 % the
risk factor is known. 74 % of those HCV cases are related to IDUs (see “Table INF-108”, “Table INF-109” and “Table INF-110”)

In 2005, the prevalence of HCV antibody among injecting drug users is between 71.8 % and 90.7 %. The prevalence among injecting drug users under age 25 lies ranges from 44.4 -78.3 % in 2005 (EMCDDA 2010).

**National drug policy on HCV prevention**

In Luxembourg one objective of the National Drugs Action Plan 2005-2009 is to improve the prevention and control of the spread of infectious diseases. Consequently the Action Plan foresees the implementation of new services such as shooting galleries and medically assisted heroin treatment. In order to optimize its impact, the Action Plan has taken into account elements from the EU Anti-Drugs Strategy (2005-2012) and the EU Drugs Action Plan (2005-2009) (see the 2007 report to the EMCDDA: www.ms.public.lu/fr/activites/analyse-statistique/drogues/syst-surveillance-epidemiologique/relis-2007-report-english.pdf).

Luxembourg also has a National Action Plan for the fight against HIV/ AIDS covering the period from 2006-2010. In this action plan prevention attention is drawn to the prevention of HIV-AIDS within specific risk groups, and drug users are one of the groups. Safe injection, substitution treatment and low threshold services (syringe exchange, health education, HCV testing, vaccination for hepatitis A and B) are mentioned as preventive interventions (www.ms.etat.lu).

In 2009 the Ministry of Health in collaboration with further health organisations has launched a project on mobile interventions for sexual health, called “DIMPS”. Aim of the project is to inform on risk behaviour and to provide rapid tests for HIV and HCV for difficult to reach populations. The DIMPS started in May 2009 and addresses in the first place drug users, sex workers and migrants. Currently the DIMPS van is visiting low threshold drug agencies, gay meeting places and immigration centres. The new Action Plan on Drugs will decide for broadening the mobile services by offering HAV and HBV vaccination in case of medical indication (Reitox National Focal Point LUXEMBOURG 2010).

**Harm reduction to prevent infectious diseases among drug users at risk**

The Drug Action Plan (2005-2009) has been evaluated by the Trimbos Institut in 2009 (Trautmann and Braam 2009). One major part of the national Drug Action Plan targeted at the reduction of risk, damage and nuisance. For this purpose the capacity of low-threshold

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8 These tables are available at www.emcdda.europa.eu/stats10/drid.
services should be expanded, also in order to reduce drug-related deaths and infectious diseases. However, the evaluation turned out that the implemented drug consumption room and the day/night centre is operational, but both do not have a permanent accommodation. Furthermore the expansion of these low-threshold services to other cities has not been realised within the period of the Action Plan.

Services such as substitution programmes and needle and syringe exchange are financed by the government. The needle exchange programme in Luxembourg is decentralised and provided in drug counselling centres, drop-in centres for sex workers and at risk populations, and low threshold services. Apart from specialised agencies needles and syringes are distributed in pharmacies and through five vending machines located in the most affected towns throughout the country. Needle and syringe exchange programmes are also implemented in prisons (see country overview at EMCDDA website: http://www.emcdda.europa.eu/publications/country-overviews/lu). Furthermore there is a programme aiming at early detection of viral hepatitis A, B, C and HIV for drug users (see: www.emcdda.europa.eu/html.cfm/index52006EN.html?by=262&value=828).

4.18 Malta

*National prevalence of HCV among drug users*

The prevalence of infectious diseases among drug users is based upon information collected by the National Agency against Drug and Alcohol Abuse, who test drug users attending the Substance Misuse Outpatient Unit (SMOPU). The most recent data is from the 2007 national report to the EMCDDA. 151 drug users were tested for hepatitis C in 2006, and 50 of them were positive for HCV (33.1%). The prevalence of hepatitis B among drug users is low and about 1.6 %. In Malta the prevalence of HCV infections remains stable and that of HBV and HIV is low (Reitox National Focal Point MALTA 2007).

The Disease Surveillance Unit reports cases of infectious disease since 2005. According to the 2007 national report there might be problems of under-reporting due to the large number of anonymous tests, and a lack of standardised procedures for notifications. Despite the national focal point remarks that the main problem among drug users is the high number of those being infected with hepatitis C.
National drug policy on HCV prevention

One of the main objectives of the National Drugs Policy 2007 seems still to be defining the present policy on drugs. One of the main objectives of the 2007 drugs policy is to achieve health protection by the prevention and reduction of drug related harm to health and society. Harm reduction measures should be applied in those drug users who are not immediately able to abstain from the use of illicit drugs. Apart from these general aims there is not specific policy on harm reduction and hepatitis C prevention. There are also no guidelines or standards on the prevention of blood-borne diseases for drug users.

Harm reduction to prevent infectious diseases among drug users at risk

There are some harm reduction programmes available in Malta. With regard to reduce blood-borne diseases among drug users there is substitution treatment with buprenorphine, risk-awareness education, information and education on safer injecting and safer sex, distribution of injecting equipment and hepatitis C testing.

The distribution of syringes started in Malta in the 1980s and reached national coverage in 1994. Needles and syringes are distributed through Health Centres: the distribution of sterile injecting equipment slightly increased in 2004 to 2006 (Reitox National Focal Point MALTA 2007). The 2007 national report stated that the syringe distribution programme works well, even though a needle-exchange programme initiated in 2002 failed.

The Substance Misuse Outpatient Unit (SMOPU) provides free screening and vaccination for hepatitis B to the drug users attending inpatient treatment at SMOPU. Hepatitis C testing and pre- and post-test counselling is offered in residential drug treatment and in prison. In prison all inmates are screened upon admission. For inmates the programme for hepatitis B vaccination started in 2007.

Treatment for hepatitis C with Interferon or Interferon/Ribavarin is provided to HCV-positive drug users if they have stopped drug use. To be eligible for HCV treatment drug abstinence including the termination of methadone treatment for at least one year is required.
4.19 Netherlands

National prevalence of HCV among drug users

Since 2003 hepatitis C only needs to be reported when it is an active infection. On basis of available information the prevalence of hepatitis C among IDUs in the Netherlands is considerably high; depending on the duration of intravenous drug use the prevalence is up to 70-80 %. Among those drug users not injecting the prevalence of HCV is about 10-15 % (see www.rivm.nl/cib/infectieziekten-A-Z/infectieziekten/Hepatitis).

The most recent data on the prevalence of HCV antibody among injecting drug users in the Netherlands is from 2006-2007. Out of 140 individuals who were tested, 40,7-56,5 % were infected (EMCDDA 2010). The prevalence of hepatitis C infection among injecting drug users under age 25 is only known from the area Southern Limburg, and the only available data is from 1996. According to these data 61.8 % of the young and tested drug users were infected with hepatitis C (EMCDDA 2010). However, it is important to consider that most people in the Netherlands smoke their drugs.

National drug policy on HCV prevention

The policy in the Netherlands pays attention to the prevention of hepatitis C in several ways. In 1997, the Ministry of Health, Wellbeing and Sport (VWS) asked the Health Council for recommendations about the prevention of HCV. The Health Council advised, among others, to inform the general population and in particular risk groups on hepatitis C infection (Health Council of the Netherlands and Committee on Hepatitis C 1997). As a result of this advice, a guideline on hepatitis C, addressing hepatitis C testing, risk assessment and health education, was published 2005 and updated in 2009 (RIVM 2005). This guideline provides information on the nature and transmission of hepatitis C. It covers issues of diagnosis, treatment, primary prevention, and standard procedures in case of a positive test result. The chapter on prevention describes basically how to offer advice to patients who are infected in the prevention of the virus transmission.

Second, there is a practical guideline on “viral hepatitis and other liver diseases”, developed by the Dutch College of General Practitioners (Bouma, van Geldrop et al. 2008). This guideline outlines the standards for diagnosis and management of viral hepatitis A, B and C and other liver diseases. Further, there exists a guideline on the specific risk for hepatitis C transmission through needle stick injuries (RIVM 2007). This guideline explains how to prevent accidents through needle sticks and what to do after such an accident.
**Harm reduction to prevent infectious diseases among drug users at risk**

In the Netherlands, the Public Health Services are responsible for the prevention and control of infectious diseases. *Screening* for HCV is often carried out by hospitals. Addiction care centres offer screening to their clients and send them through to the hospitals or Public Health Services. Most *outreach work* is carried out by low-threshold services. These services offer daytime shelter in drop-in centres for street problem drug users, ‘living room’ projects for drug-using sex workers and drug consumption rooms for chronic drug users. Other target groups of these services are injecting drug users, extremely problematic drug users, and drug users from foreign countries. Facilities providing *needle and syringe exchange* exist for more than 20 years in the Netherlands. They are available in all major Dutch cities. Needle exchange programmes are mainly provided by street workers, facilities for addiction care and, to a much lesser extent, by pharmacists (see country overview at EMCDDA website: http://www.emcdda.europa.eu/publications/country-overviews/nl).

With regard to hepatitis C the National Hepatitis Centre provides information about hepatitis addressing the general population and patient groups. Several non-governmental organisations play an important role in the actions and initiatives to prevent HCV such as trainings, education of drug users, research, and syringe exchange programs.

In 2006, a nationwide campaign has started to inform initially (intravenous) drug users about their risk of HCV-infection and possibilities for testing and prevention. In 2009, the campaign was broadened to the general population and other specific groups, like asylum seekers from high risk countries and general practitioners. The campaign runs until 2010 (www.hebikhepatitis.nl).

**4.20 Norway**

**National prevalence of HCV among drug users**

Since 1st January 2008 not only acute infections but all laboratory-confirmed cases of hepatitis C have to be reported to the Norwegian Surveillance System for Communicable Diseases (MSIS). However, the data from MSIS do not differentiate between cases of HCV involving new infection and cases where the infection occurred many years ago.

Out of the 3,411 cases of HCV reported in 2008, for half of the cases information on the mode of transmission is available. In these cases the transmission of hepatitis C was in
89% due to the use of needles. A small-scale prevalence survey from 2008, which was carried out among a representative sample of drug users in the context of needle distribution in Oslo showed: out of the 171 drug users included in the survey 41% were infected with hepatitis B infection and 68% were infected with hepatitis C infection (Reitox National Focal Point NORWAY 2010).

National drug policy on HCV prevention

The Norwegian National Action Plan on Alcohol and Drugs (2007-2010) includes objectives and strategies for prevention, treatment and rehabilitation. Harm reduction is not mentioned as an aim. In Norway there are no guidelines for the prevention (or treatment) of hepatitis C.

However, in 2009 the Norwegian parliament moved the temporary law concerning safe injection rooms into a permanent law. With this permanent Act the municipalities have a legal basis to initiate further injection rooms in addition to the one available in Oslo. Safe injection rooms are a further approach to address major health problems among active drug users (Reitox National Focal Point NORWAY 2010).

Harm reduction to prevent infectious diseases among drug users at risk

In Norway, harm reduction intervention include opioid substitution treatment, needle distribution programmes, low-threshold health services and outreach work. Needle distribution and low-threshold services have partly been developed in cooperation with voluntary organisations, and partly they are based in the health and social services.

- Needle and syringe distribution

In major cities and some municipalities programmes for the distribution or exchange of needles and syringes exists. These programmes are often available in combination with a self-service dispensers, outreach services and low-threshold contact points. In addition, almost all pharmacies in Norway sell needles and syringes to injecting drug users (see the country overview: http://www.emcdda.europa.eu/publications/country-overviews/no). In 2007, an estimated 3.3 million syringes were distributed to injecting drug users.

- Nursing services

Several municipalities have established an outreach nursing service. These services offer health checks, vaccinations, distribution of injecting equipment, guidance on nutrition and hygiene, prevention of overdoses, referrals to further health services and follow-up.

- Safe injection room
In Oslo one drug injecting room operates since February 2005. The drug injection room is accessible for problem heroin injectors who are older than 18. In the first four years until January 2009 the number of registered users had tripled to 1,276. During the 19 months from July 2007 to January 2009 in total 1,052 of the registered users made use of the injection room. The capacity of the safe injection room is limited to 24 supervised injections per day which limited the impact on the prevention of drug-related diseases (Norway National focal point, 2009).

4.21 Poland

National prevalence of HCV among drug users

In 2008, there were 2,353 new cases of hepatitis C registered in Poland. Based on this number the HCV incidence rate was 6.17 per 100,000. Compared to 2007, the incidence rate decreased by 14.5 %. The incidence of HCV infections is higher in cities than in rural areas, and higher among men than women (Stepien and Rosinska 2010).

The most recent prevalence numbers on HCV infections among injecting drug users in Poland date from 2005. About 43.7 % to 64 % of the injecting drug users seem to be infected with HCV. The prevalence of hepatitis C among injecting drug users under the age at 25 is between 30 % and 53.6 %. It is estimated that about 40-58 % of the drug users who started to inject drugs is infected with HCV (see Table INF-111, Table INF-112 and Table INF-113 from the EMCDDA Statistical Bulletin 2010). In Poland, the prevalence of HIV and HCV co-infection among IDUs is estimated to to scale up to 90 % (Aceijas and Rhodes 2007).

National drug policy on HCV prevention

There seem to be no guidelines or national policy approaches specifically addressing the prevention of hepatitis C. However, Polish drug policy supports harm reduction measures, which is reflected in the Drug Act and in the National Programme for Counteracting Drug Addiction (2006-2010). One objective of the national programme is to improve prevention and the control of the spread of infectious diseases. With regard to this objective interventions such as syringe exchange, health education and prevention of hepatitis C are promoted (see for further details: www.cinn.gov.pl/portal?id=216853).
In the second semester of 2010 a programme will start which aims to create the basis for planning a wide range strategy to prevent HCV infections and for taking actions against the hepatitis C virus. Part of the future strategy is to elaborate a) guidelines for routine researches and b) an education programme for employees of the health sector and risk groups. This programme will be executed by the National Institute of Public Health - National Institute of Hygiene (see also: www.swiss-contribution.admin.ch/poland/en/home/projects/national). According to recent information from Ms Magdalena Rosinska from the Polish Public Health and Hygiene Institute the programme planned under the Swiss contribution is based on the assessment of the current situation and discussions with experts (email from 13th of November 2010). As there is no guideline on prevention of infectious diseases in Poland, a proposal will be made for developing a national strategy and appropriate guidelines. Furthermore it is planned to pilot interventions implemented in line with the guidelines. However, due to financing procedures the implementation of the planned programme is not ensured at present.

**Harm reduction to prevent infectious diseases among drug users at risk**

Harm reduction activities have been carried out in Poland since 1989 and consist predominantly in needle and syringe exchange programmes, prevention-related educational programmes and opiate substitution treatment.

Harm reduction programmes are based in big cities and are mainly operated by NGOs; they include outreach work at the meeting places of drug users and sex workers, homeless shelters, and specialised agencies providing needle and syringe exchange. In 2007, there were 15 harm reduction projects which target at active problem drug users. In general, the geographical coverage of harm reduction is limited and respective programmes may not be available in all regions where injecting drug use is reported. Since several years, the National Health Fund aims to systematically increase the availability and coverage of those programmes which target at the reduction and treatment of infectious diseases among drug users. In particular services are supported which provide antiretroviral treatment services, vaccination against HBV, and counselling and testing for HCV and HIV (see the EMCDDA country overview: http://www.emcdda.europa.eu/publications/country-overviews/pl).

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In Poland, the implementation of drug treatment is in the responsibility of communities and provinces while drug treatment is delivered by different providers. Funding for drug treatment is primarily covered by health insurance, yet also by the public budget of communities. Drug treatment services are provided through the network of outpatient and residential healthcare centres, detoxification units, day care centres, drug treatment wards in hospitals, mid-term and long-term drug rehabilitation facilities and drug wards in prisons. The treatment system in Poland can be differentiated into three areas, namely; outpatient treatment, residential treatment and detoxification treatment.

As regards opioid substitution treatment in Poland solely methadone maintenance treatment is available. The first methadone maintenance programme was introduced in Poland in 1993. Since 2005, such treatment was only carried out by public healthcare units which have been granted permission by the governor of the region in collaboration with the Ministry of Health. According to the new drug law from 2005, NGOs can also establish and carry out opioid substitution programmes, and the first programmes provided by non-public health centres and private facilities were established in 2007 (Reitox National Focal Point POLAND 2009).

4.22 Portugal

National prevalence of HCV among drug users

Concerning the prevalence of hepatitis B and C, available data refer to the analytical tests made in drug user’s subpopulations that demand treatment in the public and accredited treatment units.

In 2007, data on hepatitis B and C showed that 4 % of the tested clients in outpatient treatment were positive for hepatitis B and 52 % were positive for hepatitis C. These percentages were very similar those found in 2005, 2004 and 2003 (Reitox National Focal Point PORTUGAL 2008). In 2008, the prevalence in active treatment clients was 3 % for hepatitis B and 50 % for hepatitis C (Reitox National Focal Point PORTUGAL 2010). However, the prevalence varies among clients in the different types of treatment (see table below).
Proportion of drug users with viral infections attending treatment in 2008

<table>
<thead>
<tr>
<th>Infections with</th>
<th>HIV</th>
<th>Hepatitis B</th>
<th>Hepatitis C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients in outpatient treatment</td>
<td>12%</td>
<td>3%</td>
<td>50%</td>
</tr>
<tr>
<td>Clients in detoxification treatment</td>
<td>12%</td>
<td>2%</td>
<td>61%</td>
</tr>
<tr>
<td>Clients in Therapeutic Communities</td>
<td>14%</td>
<td>6%</td>
<td>41%</td>
</tr>
</tbody>
</table>

National drug policy on HCV prevention

In Portugal, the National Plan for 2005-2012 includes targets to be achieved for harm reduction. The main priorities related to risk and harm reduction are: a) To establish a nationwide network of integrated and complementary interventions with public and private partners, and b) to address specific groups with risk reduction and harm minimisation programmes (Reitox National Focal Point PORTUGAL 2010).

The Institute on Drugs and Drugs Addiction (IDT) funded the National Harm Reduction Network. Main aim of the Harm Reduction Network is to prevent HIV/AIDS and related diseases such as tuberculosis and hepatitis (Reitox National Focal Point PORTUGAL 2008).

As a result of the established partnership between the IDT, the Harm Reduction Unit and NGOs a consensus about the main standards of harm reduction approaches was defined. The consensus has recently been elaborated in order to provide a guide for interventions in the field of risk and harm reduction (Carapinha and Vale de Andrade 2010). The guide covers principles, objectives, activities and methodologies to be applied for harm reduction interventions and serves also as a starting point for future research and information in this area (Reitox National Focal Point PORTUGAL 2010).

Harm reduction to prevent infectious diseases among drug users at risk

Availability and diversity of harm reduction services have been increased over years in Portugal. The most recent national report (2010) stated that 20 new harm reduction programmes have been initiated, and in 2008 there were altogether 46 programmes for harm and risk reduction all over Portugal. The programmes consist of 30 street teams, 6 mobile units, 3 drop-in centres, 2 residential centres and 5 contact points.

Drug users were contacted by outreach work, mobile units and are offered substitution treatment, screening and counselling for hepatitis and vaccination for hepatitis A and B.
In Portugal, the prevention of drug-related infectious diseases for drug users is mainly ensured through the national syringe exchange programmes. Syringe exchange is provided by drug agencies, pharmacies, mobile units, prisons and others services. Along with sterile needles and syringes other injecting paraphernalia such sterile water, alcohol swabs, filters are distributed.

- Needle and syringe exchange programmes

Drug users are given an injecting kit which includes two syringes, two disinfecting towels with 70º% alcohol, one condom, 1 ampoule of bi-distilled water, 1 filter and 1 informative leaflet. In 2008, 2,449,351 injecting kits were distributed, which represents an increase of 6 % compared to 2007. Syringes are available at 1,384 pharmacies which is half of all pharmacies existing in Portugal. In 2008, more than half of the syringes exchanges (53.8%) took place in pharmacies.

- Specific actions to prevent blood-borne diseases

The National Commission for the Fight Against AIDS in collaboration with the National Association of Pharmacies has implemented the campaign “Say no to a second hand syringe” in 1993. Since then the network supporting the campaign has been enlarged through protocols with mobile units, NGOs and other organisations. This programme was externally evaluated in 2002, and according to the evaluation results the programme is effective in the prevention of HIV infections in drug users.

- Treatment of HIV, AIDS and hepatitis

In Portugal, treatment for HIV, AIDS and hepatitis B and C is part of the National Health Service and therefore available and free for those who need it. There are constant efforts to improve implementation of free antiretroviral treatment. Out of the clients in drug treatment (outpatient, detoxification and TCs) 16 % and 74 % received antiretroviral treatment in 2008.

- Harm reduction in prison settings

In the prison setting inmates as well as staff is routinely vaccinated against hepatitis B. In 2008, altogether 1,314 prisoners and 9 staff members have been vaccinated. With regard to risk reduction and health promotion testing for HIV and hepatitis B and C, the distribution of condoms and disinfection materials is provided. In prison settings, particularly in specific prison in Paços Ferreira and Lisbon, access to a specific needle exchange programme is offered. In previously defined spaces an injection kit is distributed (Reitox National Focal Point PORTUGAL 2010).
4.23 Romania

National prevalence of HCV among drug users

According to Statistical Bulletin of the EMCDDA (2010) the prevalence of hepatitis C among drug users in Bucharest was between 60.2 % and 65.6 % in 2007. In the same year the prevalence of HCV among young drug users (until the age of 25) in Bucharest was 63.7 % (see Table INF-111 and Table INF-112).\textsuperscript{10}

\textsuperscript{10} Table INF-111 is available at http://www.emcdda.europa.eu/stats10/inftab111; Table INF-112 is available at http://www.emcdda.europa.eu/stats10/inftab112.
National drug policy on HCV prevention

In Romania the second Anti-Drug Strategy (2005–2012) focuses on illicit drugs, covering drug demand reduction, drug supply reduction, international cooperation, information and evaluation, inter-agency coordination and the provision of necessary resources. In the field of demand reduction the national strategy aims at the reduction of drug use, adequate medical, and psychological and social assistance for drug users. The Action Plan (2005–2008) comprised a detailed list of activities and its related timeframe and responsibilities for implementation. This action plan was evaluated in 2009, and a new action plan for the period 2009-2012 should be adopted in 2010.

The Action Plan (2005-2008) also includes activities related to harm reduction. In this respect access to harm reduction services has to be ensured by promoting and developing adequate programmes and policies both in community and in the penitentiary system. In detail, adequate programmes for all drug users include counselling, testing for HIV and hepatitis, vaccination against hepatitis, and treatment for hepatitis, HIV and other infectious diseases.

With regard to the current anti-drug strategy, the main objectives related to prevention are:

- To disseminate information regarding the risks and effects of drug use and misuse
- To set up a territorial network of drug prevention and counselling centers under the coordination of the National Anti-Drug Agency
- To draft standards for prevention activities necessary for the process of monitoring and evaluation, thus ensuring the quality of drug use prevention activities

Selective prevention is mostly targeted at school dropouts, the prison population, high-risk teenagers, parents, Roma groups and pupils with academic problems. National agencies and institutions with an exclusive focus on specific campaigns also carry out selective prevention programmes in recreational settings. Prevention activities in Romania are characterised by a strong focus on mass media campaigns, information-only approaches and increasing attention given to targeting vulnerable groups.

Harm reduction to prevent infectious diseases among drug users at risk

Since 2005 the National Anti-Drug Agency has coordinated activities in the drugs field at both national and local level (Reitox National Focal Point ROMANIA 2007). Drug treatment is predominately delivered in public medical units, financed from the public budget and are operated under the coordination of the Ministry of Public Health. The National
Anti-Drug Agency coordinates drug treatment provided by the Drug Prevention, Evaluation and Counselling Centers. In addition, a number of NGOs provide drug treatment such as counselling and methadone substitution treatment.

Activities to prevent infectious diseases related to drug injecting are financed mainly under the Global Fund to fight HIV/AIDS, tuberculosis and malaria, and are implemented in Bucharest by the NGOs ARAS and ALIAT. These NGOs are the main providers of harm reduction. Syringe exchange programmes are implemented only in Bucharest, which is considered to be the place with the most serious problems related to injecting drug use. However there are also further cities where this type of service would be necessary. Syringe exchange programmes are available in fixed locations and through outreach work. In 2007, a new UNODC-funded syringe programme was set up. In Bucharest, outreach programmes address injecting drug users and sex workers. The outreach programmes also provide counselling, education material and vaccination for hepatitis A and B. Treatment of drug-related infectious diseases is estimated as being relatively accessible in case of HIV infections and difficult with regard to hepatitis C.

4.24 Slovenia

National prevalence of HCV among drug users

Compared to other European countries, Slovenia is a country with a low prevalence of hepatitis B and C among drug users. In 2008, the prevalence of infections with the hepatitis B virus was 4.2 % in tested IDUs who were in methadone treatment at the Centres for the Prevention and Treatment of Illicit Drug Users. 22.3 % of the IDU clients in substitution treatment were infected with hepatitis C in 2008 (Reitox National Focal Point SLOVENIA 2010).

Due to several preventive strategies the prevalence of hepatitis C virus infection among intravenous drug users being in substitution treatment has decreased from 50-60 % at the beginning of the 1990s to about 17 % in 2006 (see: www.emcdda.europa.eu/html.cfm/index52006EN.html?by=262&value=828). For injecting drug users under the age 25 the prevalence of HCV is 12 % (EMCDDA 2010).

National drug policy on HCV prevention

In Slovenia the Resolution on the National Programme on Drugs 2004–2009 builds the strategy to deal with illicit drugs. The aim of the resolution is to encourage preventive
actions in the area of drugs. It includes various programmes to reduce the demand for drugs in order to minimise the number of new drug users among the younger generation, to prevent first contact with drugs and to rise the age of onset. The programme’s main priorities are: to develop the information system in the field of drugs; to increase the share of drug users included in different programmes; to support NGOs; to define and evaluate standards for financing programmes over several years; to establish a coordination system in cooperation with faculties and research institutes; to improve programmes in prisons to prevent drug use; and to establish a network of Local Action Groups (LAGs). One of the general aims of the resolution in the area of drugs is to support the development of programmes that contribute to either maintain or reduce the number of drug users infected with AIDS and hepatitis B and C.

In Slovenia, the “National Consensus Guidelines for the Management of Hepatitis C in drug addicts” has been developed in 2007 and published in a journal in 2009 (Maticic and Kastelic 2009). The guideline is based on an expert consensus of different disciplines (infectologists, gastroenterologists, psychiatrists, drug addiction specialists, virologists, epidemiologists, pathologists, social workers), and aims at the management of hepatitis C in drug addicts. Drug addicts in treatment in one of the 18 Centres for Prevention and Treatment of Drug Addiction should be provided with diagnosis, treatment and follow-up by the hepatitis specialists. The guideline also comprises procedures for counselling and prevention of hepatitis C.

Harm reduction to prevent infectious diseases among drug users at risk

Programmes of harm reduction for injection drug users include low threshold services, information and education on risks of drug use, counselling, needle exchange, outreach work, day centres and methadone maintenance programmes. In Slovenia, these programmes are provided mainly through NGOs.

Methadone treatment started in 1990. Maintenance treatment is available on a national level and exists at present in 20 cities. Other medications applied for opioid treatment are buprenorphine, subutex, and substitol. Opioid substitution treatment is also widely available in prisons. Needle and syringe exchange programmes have been started by the Harm Reduction Association “Stigma” in 1991. Fixed needle exchange programmes exist in five cities, and another 15-20 smaller cities are covered by outreach and mobile units. There is also a pharmacy-based availability of injection equipment. About 2,000 clients use the needle and syringe schemes (see country overview at EMCDDA website: http://www.emcdda.europa.eu/publications/country-overviews/si).
In Slovenia, testing for HCV is provided upon entry to drug treatment. However, anonymous and voluntary testing for HCV is only provided once a year, while all persons are offered anonymous and voluntary testing on HIV in the larger Slovenian cities. In prison, only individuals infected with HIV are offered testing for hepatitis C (EHRN 2007). Treatment and care is accessible and available for drug users.

Harm reduction programmes for drug users mainly exist in the capital city of Ljubljana and other regions and cities (i.e. Koper region, city of Celje, city of Ilirska Bistrica, etc.). A limited availability of harm reduction programmes is observed in medium and smaller towns. According to the opinion of Stigma, harm reduction must be expanded geographically and be improved by the implementation of services for homeless drug users, especially day and night shelters.

4.25 Slovakia

National prevalence of HCV among drug users

Data on the prevalence of hepatitis C infections among drug users are only available for those requesting treatment at the Centre for Treatment of Drug Dependences in Bratislava. Based on the treatment data 50% of the IDU clients were found to be infected with hepatitis C in 2008. In the previous years the prevalence of HCV infections among IDUs in the respective treatment centre was 48.8% in 2005, 40.6% in 2006 and 48.3% in 2007 (Reitox National Focal Point SLOVAKIA 2010).

National drug policy on HCV prevention

HCV prevention is a part of the pillar on prevention and reduction of risks related to the spread of infectious diseases among drug users of the Slovak Republic National Anti-Drug Strategy (2009–2012). The priorities of the National Strategy are the reduction of demand and supply, coordination and cooperation, and information, research and evaluation. Harm reduction as strategy to prevent blood-borne diseases is not defined explicitly as one priority area.

However, the National Drug Strategy mentioned the following objectives for the prevention of drug abuse and related risks:

- Targeted prevention of high-risk behaviour of drug users
Ensure access to services to reduce damages caused by drugs with the aim to slow down the spread of HIV/AIDS, hepatitis C and other drug-related blood-borne diseases

Provide access to healthcare for drug-using prisoners with the aim to prevent the harmful effects of drugs

**Harm reduction to prevent infectious diseases among drug users at risk**

In Slovakia, harm reduction services are rather limited due to insufficient funding. In fact, in 2008 several harm reduction programmes outside the Bratislava region terminated their activities (Reitox National Focal Point SLOVAKIA 2010). Those harm reduction programmes available mainly consist of needle and syringe programmes.

The exchange or distribution of sterile needles and syringes constitute the major activities of low-threshold organisations. In 2008, a total of 223,721 syringes were provided to the clients of these facilities. In Bratislava sterile injection equipment is also available at the Centre for the Treatment of Drug Addiction. Furthermore the majority of the pharmacies in Slovakia sell needles and syringes to drug users.

**4.26 Spain**

**National prevalence of HCV among drug users**

In Spain, between 65 % and 90 % of injection users are infected with hepatitis C, depending on the geographic area and origin of the sample studied (Reitox National Focal Point SPAIN 2007). In the most recent report to the EMCDDA it is shown that between 60 % and 90 % of injecting drug users are HCV-positive. Of the prison population 27 % are infected with hepatitis C (Reitox National Focal Point SPAIN 2010).

Data from a cohort study of drug users carried out in Barcelona, Madrid and Seville in 2005 show, that the incidence of HCV among young IDUs is extremely high with 34.8/100 person-years (CI 95%: 26-46/100). While the prevalence of HCV infection has remained quite stable, the prevalence of HIV infection seems to decrease slowly (Reitox National Focal Point SPAIN 2007).

A study among 3,247 IDUs visiting AIDS Information and Prevention Centers of the Valencian Community from 1990 to 1996 demonstrated that there is a high level of co-infection with HIV and HCV. Out of the sample 45.1 % were infected with both HCV and HIV. Among young injection users in Madrid, Seville and Valencia, who were captured in
the region from 2001-2003, 49.8 % were infected with HCV and 23.4 % were co-infected with HCV and HIV (for the studies see the Reitox Report of Spain 2007).

**National drug policy on HCV prevention**

In Spain, there is no specific policy on hepatitis C prevention among drug users. However, there is a broad harm reduction policy including the prevention of infectious diseases such as hepatitis C.

In addition, a number of guidelines and protocols on the control, prevention and treatment of hepatitis C have been developed in the last years. In 2003, a guidance on the control and prevention of hepatitis C testing has been developed, in Catalan language. The guidance covers testing for hepatitis C, vaccination for hepatitis A and B, advice on safer use, and risk assessment (Buti i Ferret, Bruguera i Cortada et al. 2003). In 2004, three different documents have been developed to provide practical guidance on the issue of hepatitis C. Two provide more general information on hepatitis C and deal with the prevention of HCV through testing, awareness for risks related to tattooing and piercing (Arandia, de Castro Laiz et al. 2004; Vera, Madrid et al. 2004). The other one is focused on treatment of acute HCV infection in the prison setting (Sogorb 2004). In 2007, a further protocol on hepatitis C was published which includes instructions for HCV testing (Tortajada, Ricote et al. 2007). Finally a guidance for the clinical practice concerning testing for hepatitis, advice on safer use and safer sex, risk assessment and blood awareness was recently developed (García, Sierra et al. 2009).

**Harm reduction to prevent infectious diseases among drug users at risk**

Like most of the European countries also in Spain there are drop-in centres and mobile units, and outreach work. Mobile units provide substitution treatment with methadone, first aid and carry out diagnostic tests. Drug users are offered substitution treatment in community and in prison, condoms, information and education on safer injecting and safer sex, syringe exchange programmes and drug consumption rooms.

At present the high prevalence of hepatitis C is regarded as the major problem in Spanish drug users. Accordingly efforts are made to improve screening and prevention and to facilitate access to treatment and medical follow-up (Reitox National Focal Point SPAIN 2010)

- Prevention of infectious diseases
Health education, screening for hepatitis C and counselling is provided in community harm reduction agencies, drug treatment centres and in prisons. However, the implementation of these services seems to vary across the country. With exception of some penitentiary centres, drug users have access to bleach and condoms. In a few cities peer work education and sniffing tools are provided. In some prisons aluminium paper and cigarette holders for smoking is provided.

- Needle and syringe exchange

Needles and syringe exchange is available in community and in prisons. As regards prisons, the accessibility and utilisation of sterile injecting equipment is rather different in existing penitentiary institutions. In 2008, sterile syringes were distributed in 34 penitentiary institutions. Along with needles and syringes further injecting paraphernalia (sterile water, alcohol swabs, filters) are distributed – but not at all existing facilities targeted at drug users.

- Drug consumption rooms

In Spain there are seven “Safe Injection Rooms”; five rooms operate in Catalonia, one in Madrid and the other Bilbao. These facilities are located in areas where the population with drug-related risk behaviour is concentrated. The drug consumption rooms have been visited by 6,221 drug users in 2008.

- Vaccination campaigns

Vaccination campaigns for hepatitis B addressing drug users are reported to be carried out in an almost systematic way in outpatient treatment, detoxification in hospitals and in penitentiary centres.

- Prison setting

In Spain blood screening, vaccination, provisions of disinfectants and condoms is provided in all prisons. Furthermore prevention programmes and health education have been developed, directed not only to drug addicts but also to inmates being at risk to start drug use in prison, and to first offenders and younger prisoners.

4.27 Sweden

National prevalence of HCV among drug users

In Sweden, reporting of the infectious diseases became mandatory under the Swedish Communicable Diseases Act. Since 1990, almost 28,000 cases have been reported to the
Institute for Infectious Disease Control as infected via intravenous drug use. This group accounts for two thirds of all reported cases of infections with hepatitis C.

Among injecting drug users the prevalence of HCV seems to be stable at a high level. In the 2010 national report to the EMCDDA it is stated that various studies conducted during the last 15 years found a prevalence of HCV infections among IDUs between 60% and 92% (Reitox National Focal Point SWEDEN 2010)

National drug policy on HCV prevention

The current National Action Plan against drugs (2006-2010) continues the Swedish policy which follows the overall aim to create a society free from illicit drugs. In this respect main actions are directed to reduce the number of individuals initiating drug use and to decrease access to illicit drugs.

Even though harm reduction is no major objective of the drug policy in Sweden, a new law on the exchange of syringes and needles came into force in 1st July 2006. The purpose of the law is to prevent the spread of infectious diseases, in particular of HIV, by combining the exchange of syringes and needles with interventions to motivate drug users to attend treatment. The law provides the basis to initiate services, however, these services need the permission of the National Board of Health and Welfare (Reitox National Focal Point SWEDEN 2010). The National Board of Health and Welfare has published complementary regulations about quality and staffing requirements for the exchange of needles and syringes as well as demands for counselling, testing for HIV, hepatitis B and C, and vaccination against hepatitis offered to drug users.

In Sweden, a national strategy to combat HIV and other communicable diseases was launched by the government in 2005 (The Swedish Government 2005). The strategy aims at the prevention of the spread of HIV infection and other blood-borne infections. The comprehensive paper covers a wide range of topics related to IDUs such as interventions and prevention for IDUs. The national strategy also includes a bill for the new law on needle and syringe exchange programmes as mentioned above.

Harm reduction to prevent infectious diseases among drug users at risk

In consideration of the national drug policy in Sweden, the national Drugs Commission advises against low-threshold programmes, safe injection rooms and legal prescription of heroin. At the same time the Drugs Commission admitted that drug users can be offered support without the requirement of an immediate and/or long-lasting drug-free life. How-
ever, the predominant harm reduction approach is to exchange needle and syringes to intravenous drug users.

In this respect the National Board of Health and Welfare presented the new regulations in February 2007. Key aspects of the regulations are:

- Procedures for County Councils to apply for establishing a NSP are defined. The application needs to include an estimation of number of potential service users and a plan for the provision of additional care services such detoxification, drug treatment and aftercare.
- NSPs are obliged to inform clients about the risks of injecting, and to offer additional services including screening and vaccinations for infectious diseases.
- Clients of NSPs must be a documented injecting drug user and are not allowed to be in hospital care or in addiction treatment.
- NSPs are required to be managed by a medical doctor and employ medical staff qualified in addiction care, infectious diseases and with specialist competence in psychiatric care.

In general the Swedish law allows each of the 21 regions in Sweden to introduce needle exchange programmes (see the country overview: http://www.emcdda.europa.eu/publications/country-overviews/se). However, at the end of 2008 no needle exchange programme has been established in addition to the two programmes already in place in southern Sweden (Lund since 1986 and Malmö since 1987). In Sweden, pharmacies are not entitled to sell needles/syringes to drug users. The two services in Lund and Malmö distributed 116,648 syringes in 2007.

4.28 United Kingdom

National prevalence of HCV among drug users

In 2008, a total of 69,864 diagnoses of hepatitis C infection had been reported in England. In Wales 4,047 diagnoses of hepatitis C infection had been reported in 2008, in Northern Ireland there were a total of 1,291 HCV diagnoses, and in Scotland a total of 25,355 persons had been diagnosed hepatitis C positive. Over 90 % of diagnoses with risk factor information result from infections acquired through injecting drug use (Reitox National Focal Point UNITED KINGDOM 2010).

Based on a survey carried out in 2008 in England, Wales and Northern Ireland among IDUs, the prevalence of hepatitis C has shown to be at around 40 %. Amongst current IDUs participating in the survey, the prevalence of hepatitis C has increased from 33 % in
2000 to 40 % in 2008. In Glasgow 358 IDUs have been surveyed at needle exchanges in 2007. Among the participants the estimated seroprevalence of hepatitis C was 74 % (Reitox National Focal Point UNITED KINGDOM 2010). The prevalence of HCV increased with age from 19 % among those aged under 25 years to 55 % among those aged 35 years and over (EMCDDA 2010; Reitox National Focal Point UNITED KINGDOM 2010). An increase of HCV infections among injecting drug users under the age of 25 was reported from Scotland (EMCDDA 2010; Reitox National Focal Point UNITED KINGDOM 2010).

**National drug policy on HCV prevention**

The growing importance of hepatitis C as a public health issue resulted in 2002 in the “Hepatitis C Strategy for England” (Department of Health 2002). In cooperation of existing initiatives and stakeholders suggestions were made on how prevention, diagnosis and treatment of hepatitis C could be improved. The main aims of this strategy were to prevent the spread of hepatitis C infections, to identify persons with chronic infection by increasing testing for hepatitis C, and to offer specialist advice and appropriate treatment.

In 2004, a “Hepatitis C Action Plan for England” was developed due to the awareness that intensified action are needed to improve prevention, diagnosis and treatment for HCV (Department of Health 2004). The Action Plan is based on best practice, and was intended to build the framework for the implementation of the hepatitis C Strategy. The Action Plan outlines four major actions which are

- Action 1: Surveillance and research
- Action 2: Increasing awareness and reducing undiagnosed infections
- Action 3: High-quality health and social care services
- Action 4: Prevention.

In Wales, the Blood-borne Viral Hepatitis Action Plan for Wales 2010-2015 has recently been published (Welsh Assembly Government 2010). Its development is based upon available evidence, local research and HCV strategies in Scotland and in England. With regard to the prevention of hepatitis C the following actions have been mentioned: Prevention, diagnosis of chronic infections and management and treatment of HCV infections. Among other topics, the Action Plan includes a detailed description of bench marks to be reached for current drug injectors. In consideration of the current knowledge on what works, the following three main targets and related actions are defined for prevention:
1. Reducing the frequency of injecting drug use
   - Increase the proportion of individuals accessing and being retained in substitution treatment
   - Ensure drug treatment is available for homeless drug injectors, young people and recent onset injectors
   - Implement intervention programmes to reduce initiation into injecting amongst vulnerable individuals (disadvantaged children and young people)

2. Reducing the risks associated with injecting drug use
   - Reduce the frequency of ‘direct’ needle and syringe sharing and ‘indirect’ paraphernalia sharing through availability of high quality needle and syringe exchange services throughout Wales
   - Ensure that high quality opioid substitution treatment is available, with optimal dosing to maximise retention in treatment
   - Implement intervention programmes to reduce injecting risk behaviour amongst current injectors

3. Increasing the diagnosis of infection amongst those with a history of risk for acquisition of the virus

   In *Northern Ireland* an Action Plan for the prevention, management and control of hepatitis C has been launched in 2007 (Department of Health 2007). One part of the plan is focussed specifically on the prevention of hepatitis C transmission in IDUs. Respective actions aim at raising awareness of risk behaviours amongst IDUs through the development of
   - an information leaflet for IDUs on blood borne viruses including hepatitis C;
   - training, information and guidance on blood borne viruses for professionals including healthcare workers to raise awareness for blood-borne diseases;
   - local multi-agency arrangements for hepatitis C prevention which are carried out in cooperation with Community Addiction Teams and will link into other related areas such as sexual health;
   - needle and syringe exchange schemes.

Scotland also developed Action Plans on hepatitis C. The Scottish Action Plan consists of two phases. Phase I was undertaken in the period from September 2006 to March 2008, and was mainly aiming at the generation of an evidence basis for the actions to be implemented in Phase II. Evidence was collected through numerous surveys and other investigations, and was used to make proposals for the development of hepatitis C services during Phase II. Phase II was from May 2008 to March 2011 and the developed “Hepatitis C Action Plan for Scotland” was basically designed to improve all HCV prevention, testing
and diagnosis, and treatment and care for those persons infected with hepatitis C (The Scottish Government 2008). Related actions range from education to young people in schools about the dangers of injecting drug use to the treatment of infected persons with antiviral drugs. As a result from the implementation of the Phase II Action Plan a guideline on best practice for services providing injecting equipment has been recently developed (The Scottish Government 2010). The Scottish Government provides funding to the Health Service Boards in Scotland to improve Hepatitis C. A major concern of the guideline is the provision of needles, syringes and other injecting paraphernalia to IDUs.

**Harm reduction to prevent infectious diseases among drug users at risk**

In England, Wales and Scotland there is a variety of initiatives and programmes addressing explicitly the prevention of hepatitis C and drug-related harms. A number of expert groups dealing with recommendations for the prevention of infectious diseases stressed the importance of providing information and practical advice on safer injecting practices in order to prevent blood-borne virus transmission. In line with these recommendations the National Treatment Agency (NTA) started to implement harm reduction programmes focusing on information campaigns, improving service delivery of harm reduction services and improved surveillance of service provision.

Furthermore the ‘Harm Reduction Works’ information campaign provides targeted harm reduction and advice to drug users and service providers. Information materials such as posters and DVDs are distributed, covering topics such as safer injecting, hepatitis C testing and strategies to avoid infection (Reitox National Focal Point UNITED KINGDOM 2010).

The Prevention Working Group on hepatitis C prevention published a report on HCV prevention among IDUs and suggested a variety of interventions to be provided by drug services (ACMD 2009). The Prevention Working Group recommended for instance to offer sterile injecting equipment in services that provide methadone and to increase hepatitis C testing of service users by all services.

With respect to the prevention of blood-borne diseases drug users are offered community pharmaceutical treatment, information on safer injecting and safer sex hepatitis B vaccinations, testing and counselling for hepatitis B and C and HIV, and needle exchange. Substitution maintenance treatment with oral methadone is the most common pharmacological treatment used in treatment of heroin addiction; buprenorphine, injectable opiates such as injectable methadone and injectable diamorphine are also available. **Needle and syringe exchange** schemes for injecting drug users were introduced in the mid-1980s.
Since 2004 over 90% of Primary Care Trusts in England now have such programmes and more than 27 million needles are exchanged each year (Department of Health 2004). Needle and syringe exchange is offered by a wide range of services, including specialist syringe exchange services, outreach and mobile units, pharmacies, and accident and emergency services.

Due to the importance of the ongoing development of high-quality and accessible needle exchange services, the National Institute for Health and Clinical Excellence has published a guidance on the optimum provision of needle exchange services (NICE 2009). The guidance is targeted mainly at health professionals and drug workers who are involved in the provision of needle and syringe programmes.

In Scotland, the Scottish Drugs Forum (SDF) has set up a project addressing young drug users at risk. Aim of the project is to reduce hepatitis C among this group. The project will be funded for a two year period and will include training for youth workers who deal with vulnerable young people (see: http://www.sdf.org.uk/sdf/2953.html).
References (WP2)


Department of Health and Children, Ed. (2005). The prevention of transmission of blood-borne diseases in the health-care setting. Ireland, 


RIVM (2007). Richtlijn Prikaccidenten [national guideline needle stick injuries]. The Netherlands, RIVM, Centre for Infectious Disease Control.


Annex 1: Questionnaire on HCV prevention guidelines and standards

Centre for Interdisciplinary Addiction Research (CIAR)
Project coordinator: Dr. Heike Zunthold
zunthold@uki.de

Responsible project partner

Request for information on guideline(s) or standards1 for HCV prevention

Dear colleagues,

the CIAR is currently conducting a European project on the “Identification and optimisation of evidence-based HCV prevention in Europe for young drug users at risk”. One part of the project – funded by the European Commission – is to identify and collect guidelines, standards or national policy papers for the prevention of hepatitis C among drug users. In this respect we want to get information about national HCV prevention guidelines/standards existing in the European Union Member States and targeting at drug users. In case there is a national policy on the prevention of Hepatitis C among drug users, we are also interested in information about this policy.

In detail, we would kindly ask you

- to provide information on guideline(s) or standards - or at least a national policy - on HCV prevention available in your country.
- To fill in the questionnaire. Please use for each prevention guideline/standard/policy paper a separate questionnaire.
- Please send this document back to the email of the responsible project partner. In addition we would like to get a copy of the guideline/standard/policy paper, either by email or by mail.

Remark:
Guidelines/standards for HCV prevention targeted at drug users might be part of a general hepatitis C prevention for the general population or a chapter on prevention might be included in a guideline for the treatment of Hepatitis C. In both cases we would like to get information on these documents. The same applies if there is a national strategy or policy on the prevention of hepatitis C.

Many thanks for your support

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1. Guidelines for the prevention and control of infectious diseases and public health threats are comprehensive, systematically developed statements to improve the quality of professional practice and patient care. They aim at the improvement of quality and effectiveness of prevention approaches for the main population as well as for high-risk groups.

2. Quality standards are generally accepted principles or sets of rules for the best/most appropriate way to implement an intervention. Frequently they refer to structural (formal) aspects of quality assurance, such as environments and staff composition. However they may also refer to aspects of content, processes and evaluation of the intervention.
0. To my knowledge there are no guidelines/ standards/ national policy papers available.

☐ YES       ☐ NO

If the answer is NO, there is no need to fill in the following lines:
BUT please send this questionnaire back to the Responsible project partner!

A. Basic information on the guideline/ standard/ national policy

1. Title of the guideline/ standard/ policy paper.

2. With regard to the definition (see footnote): Is the document a guideline or standard for the prevention of hepatitis C?

   Guideline
   Standard

   The document refers to a national policy/ strategy: ☐ YES

2a. Please provide further short explanation on what the document is about.

3. A copy of the guideline / standard or policy paper is available and will be submitted.

☐ YES         ☐ NO

B. Specific information on the guideline/ standard/ national policy paper

4. Year of publishing the guideline/ standard/ national policy paper.

5. Relevant website where guideline/ standard/ national policy paper is available.


7. Who has edited the guideline/ standard/ national policy paper? Please name the editor(s) that are relevant for citation.

8. Who are the authors of the guideline/ standard/ national policy paper? Please name the individual authors or - in case of an institution or group - the respective institution or group.
14. Is the guideline/standard/national policy paper directed to a specific setting?

☐ No
☐ YES, to community services  ☐ health sector (hospitals, GPs)
☐ YES, to prison services  ☐ drug agencies
☐ YES, to prison services  ☐ harm reduction services

15. Which risk group is specifically addressed with the guideline/standard/national policy paper?

Please tick the group(s) applied.

☐ No information
☐ Risk group is not specified
☐ Young drug users  ☐ IDUs
☐ Prisoners  ☐ Non-infected drug users  ☐ Migrants
☐ Other, specify  ☐ Sex worker

16. Who belonged to the group that has developed the guideline/standard/national policy paper?

The guideline/standard/national policy paper development group included individuals from the following groups:

☐ No information
☐ Group is not specified  ☐ Clients/patients
☐ Health + social professionals  ☐ Physicians  ☐ Researcher
☐ Other, specify  ☐ Politicians

C. Evidence base of the guideline/standard/national policy paper

17. Are aspects of or criteria for evaluation of prevention included in the guideline/standard/national policy paper?

18. On which consensus/evidence-base has the guideline/standard/national policy paper been developed?

19. Has evidence been systematically considered and elaborated in development of the guideline/standard/national policy paper?

20. Is the evidence reported and part of the guideline/standard/national policy paper?

Thank you very much

Do you want to add additional information?
### Annex 2: Details of the guidelines, standards and policy paper on HCV prevention considered for analyses

<table>
<thead>
<tr>
<th>Country</th>
<th>Title of the guideline / standard / policy paper</th>
<th>Year of publication</th>
<th>Authors</th>
<th>Institution</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>[Consensus for the treatment of Hepatitis C]</td>
<td>2002</td>
<td>Rainer Pöhni and Jörg Pont</td>
<td>Conference of prison physicians, held in June 2002</td>
<td></td>
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</table>

11 Titles which are edited in squared brackets have been translated into English language.
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Czech Republic</td>
<td>[The standard for infectious hepatitis treatment among drug users]</td>
<td>2008</td>
<td>Jan Galsky, Petr Husa, Petr Kumpel, Stanislav Plisek, Jan Sperl, Petr Urbanek, Jiří Dvoracek, Petr Popov, Tomas Zabranksy</td>
<td>Bulletin of the Ministry of Health of the Czech Republic</td>
<td></td>
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<tr>
<td>Denmark</td>
<td>National handlingsplan til forebyggelse af hepatitis C blandt stofmisbrugere</td>
<td>2007</td>
<td>Dr Jan Fouchard, Medical Officer MD, PhD</td>
<td>National Centre for Health Promotion and Disease Preventio, Danish National Board of Health</td>
<td><a href="http://www.sst.dk/publ/Publ2007/CFF/Stofmisbrugere/Forebyggelse">http://www.sst.dk/publ/Publ2007/CFF/Stofmisbrugere/Forebyggelse</a> HepC_stofmisbrugere.pdf</td>
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<tr>
<td>Hungary</td>
<td>[Hungarian translation of the EMCDDA guideline: Guidance on provider-initiated voluntary medical examination, testing and counselling for infectious diseases in injecting drug users]</td>
<td>2009</td>
<td>H. Blystad and L. Wiessing</td>
<td>EMCDDA Lisbon Hungarian translation: Tarján Anna, Dr. Dudás Mária National Centre for Epidemiology Budapest</td>
<td></td>
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**Notes:** 11. Year of publication.
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<tbody>
<tr>
<td>Slovenia</td>
<td>[National Consensus guidelines for the management of hepatitis C in drug addicts]</td>
<td>2007</td>
<td>Mojca Matičič and Andrej Kastelic Consensus was made by the national interdisciplinary group for viral hepatitis and drug addiction at the 2nd Slovenian National Conference on Hepatitis C in Drug Addicts, January 20, 2007, Ljubljana, Slovenia</td>
<td>Ljubljana University Medical Centre - Clinic for Infectious Diseases and Psychiatric Hospital Centre for Treatment of Drug Addiction Ljubljana</td>
<td></td>
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<td>Year of publication</td>
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<tr>
<td>Spain</td>
<td>Guia per a la prevenció i el control de l'hepatitis C</td>
<td>2003</td>
<td>Maria Buti i Ferret, Miquel Bruguera i Cortada, Glòria Carmona i Parcerisa, Àngela Domínguez i García, Joan Ignasi Esteban i Mur, Rafael Esteban i Mur, Jaume Guardia i Massó, Silvia Sauleda i Olivella, Josep Vidal i Tort</td>
<td>General Directorate for Public Health of the autonomous community Catalonia</td>
<td><a href="http://www.gencat.cat/salut/depsalut/html/ca/dir2094/guiahepatitisc.pdf">http://www.gencat.cat/salut/depsalut/html/ca/dir2094/guiahepatitisc.pdf</a></td>
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<tr>
<td>The Netherlands</td>
<td>[National guideline on needlestick Injuries] Richtlijn prikincidenten</td>
<td>2007</td>
<td>RIVM, Centre for Infectious Disease Control</td>
<td>RIVM</td>
<td><a href="http://www.rivm.nl">www.rivm.nl</a></td>
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