Micro-elimination in networks of people who use drugs

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Principles for micro-elimination among people who inject drugs
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HIGH PREVALENCE + HIGH INCIDENCE = DUAL APPROACH

8% of current HCV infections among PWID (0.23%)

Transmission among PWID will account for 43% of incident infections from 2018-2030

HIC: 79%, LMIC: 38%

Addressing transmission and scaling up treatment will be necessary to eliminate HCV

8% of current HCV infections among PWID (0.23%)

Significant burden of disease attributable to IDU


A basket of evidence-based approaches for prevention

- **OPIOID AGONIST THERAPY (OAT)**
- **NEEDLE AND SYRINGE PROGRAMS (NSP)**
- **HCV TREATMENT AS PREVENTION**

Rapid DAA scale-up is optimal

Figure Courtesy of Homie Razavy
NSP & OAT are required to optimize HCV treatment-as-prevention

Martin et al., 2013. Combination interventions to prevent HCV transmission among people who inject drugs: Modeling the impact of antiviral treatment, needle and syringe programs, and opiate substitution therapy. Clinical Infectious Diseases, 57(Suppl 2): S39-S45.
Micro-elimination within social networks of people who use drugs
Quantifying elimination: The HCV cascade of care

Suitable indicators are routinely collected & stored for administrative purposes; but PWID are ‘hidden’ within databases.
What factors facilitate or impede micro-elimination within networks of PWUD?

- The illicit nature of drug use
- The social contexts PWUD live in and competing needs can increase risk, deter people to be reached, and to follow the steps needed to achieve sustained viral response
- This translates in fear, mistrust, defiance, wishful thinking, stigma and discrimination
- But also solidarity, trust in their peers, shared experiences
Integrating network in approaches help reduce prevalence among PWID

HCV prevalence after 10 years in Networks in Melbourne

Example from Melbourne, Australia

HCV prevalence after 20 years in extended networks of PWID

An example from the USA

Conceptualising access to HCV care for people who inject drugs

What needs to be done?
Selected case studies
Adapted to each environment

Attract everyone as a collective movement

WHAT NEEDS TO BE DONE

Simplify treatment

Expand settings to test, treat and prevent

Expand access to medication
Case #1: Montréal, QC Canada
WHAT NEEDS TO BE DONE

Competing needs and mistrust of health care system; universal care but not equity

Expansion of OAT in the midst of the opioid crisis; few treatment options for stimulant use; need to expand role of nurses and peers in harm reduction and other non-traditional settings

Attract everyone as a collective movement

Simplify: RNA reflex testing; changes in practice to reduce genotype and fibroscan as usual practice

Simplify treatment

Expand settings to test, treat and prevent

Expand access to medication

Treatment entirely covered; GP can prescribe but often reluctant
Case #2: Kenya, Africa
WHAT NEEDS TO BE DONE

Pilot project in outreach and HR service; coupling with research
From pilot to regional expansion

As a result of this Pilot: Improved awareness of hepatitis

Limited access to diagnostics;

Education and counseling sessions as pre-treatment; HCV/HBV/HIV – syndemic approach
Involvement of peers
Testing and treatment in Harm reduction and OAT;

Treatment guidelines; need for national guidelines and funding strategy;
Registration of new pangenotypic crucial; and additional need for funding to support treatment cost

Adapted from: Abigael Lukhwaro MDM; INHSU 2018
Case #3: Netherlands
WHAT NEEDS TO BE DONE

Attract everyone as a collective movement

Large multi-media campaign targeting OAT clinics and at-risk populations

Simplify treatment

Medication covered but has to be paid for by patient before reimbursement;

Expand access to medication

Hospital based treatments only

Expand settings to test, treat and prevent

Case finding of those previously diagnosed; «Breakthrough project» Multidisciplinary concertation and clear pathways for linkage to care involving infect disease specialists, hepatologist, addiction care etc.

CONCLUSION
Continuum of care for hepatitis C with adapted interventions – Test and treat with simplified protocols and delegate roles to those best suited to succeed

**At risk but not infected**
- Evidenced-based interventions
  - Outreach and screening
  - Opioid Agonist Treatment
  - Safe sources of injection material

**Chronic HCV diagnosed**
- Evidenced-based interventions
  - Targeted outreach programs
  - Rapid testing
  - Expansion of testing

**Linked to care**
- Evidenced-based interventions
  - Co-located services
  - Peer-driven interventions
  - Nursing support

**Prescribed treatment**
- Evidenced-based interventions
  - Peer-navigators
  - Nurse educators
  - Expedited evaluation
  - Simplified treatment and co-location

**Achieved SVR**
- Evidenced-based interventions
  - Peer-navigators
  - Nurse educators
  - Expedited evaluation

**At risk of reinfection**
- Evidenced-based interventions
  - Outreach and screening
  - Opioid agonist Treatment
  - Safe sources of injection material

Interventions
- HBV vaccination; STIs; mental health
- Attract and retain youth in harm reduction and addiction services
- Network interventions

**Interventions**
- Peer navigators; testing in communities, addiction and harm reduction settings
- Peer and advocacy; Role of community, primary care, addiction and mental health services
- Enhancing engagement in care; Role of addiction care
- Role of all to foster engagement during therapy
- Role of PreP to prevent HIV Engagement, advocacy and continued care
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