Thirty years of harm reduction in the Netherlands

HCV elimination ahead?

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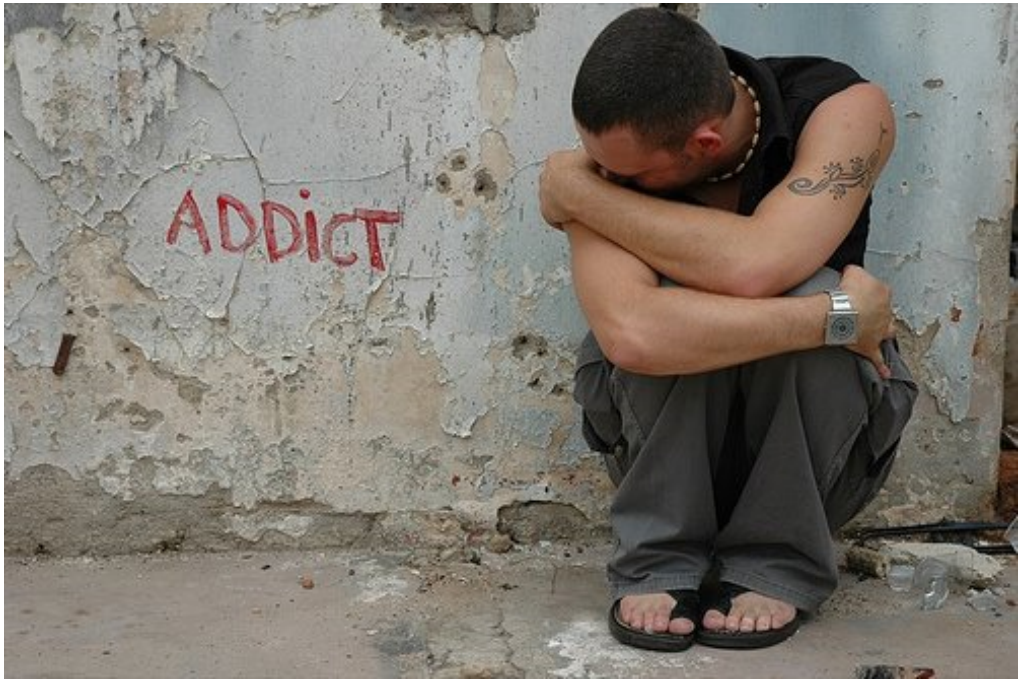
Confession

- 30 years …
- 3 topics: drug use, harm reduction, HCV …

- in 15 minutes …

- IT DOESN'T FIT!!



Disclosure

Esther Croes received *no* personal grants/ fees/ travel reimbursement for consultancy or research.

Trimbos Institute received public-private funding for two projects in which Esther Croes was project leader (2011-2014)

Public: Ministry of Health & ZonMW (the Netherlands organisation for Health Research and Development)

Private: Roche, MSD, Janssen, Gilead, Abbvie

Drug use in the eighties

- The heroin epidemic
- Amsterdam: the “magic centre” of the world where drug use is tolerated
- Number of heroin addicts increases rapidly
- >>50% injecting
- Hundreds of overdoses/ year
- AIDS epidemic

Drug use anno 2017

- Opiates:
  - Rapid decrease in use: 17,000 (2009) - 14,000 (2012)
  - 9,000 in treatment in addiction care (data 2015)
  - <1,000 drug injectors in the whole country (!!!) (2015)
  - Ageing population (mean age: 48 yrs; 4%<30 yrs)
  - Majority is in contact with health professionals
- Top 3 drugs in population (2014):
  1. Cannabis (ever use 24.3%)
  2. Ecstasy (7.6%)
  3. Cocaine (5.3%)
- Top 3 substances in addiction care:
  1. Alcohol
  2. Cannabis
  3. Opiates

Harm reduction in the NL

- Pragmatic approach
- Methadone prescription since 1968; large programs since the 80s
- Relapse in heroin use is not “punished”
- >70% of heroin users is in a methadone program
- If methadone does not work: medical heroin (n=1000)
- Large NSP’s (but decreasing need)
- Drug & alcohol consumption rooms
- Sheltered living projects
- Living room projects
- …
- Adagium: combination of HR measures is most effective

1+1=??

- Is the pragmatic HR approach responsible for the low number of injectors?

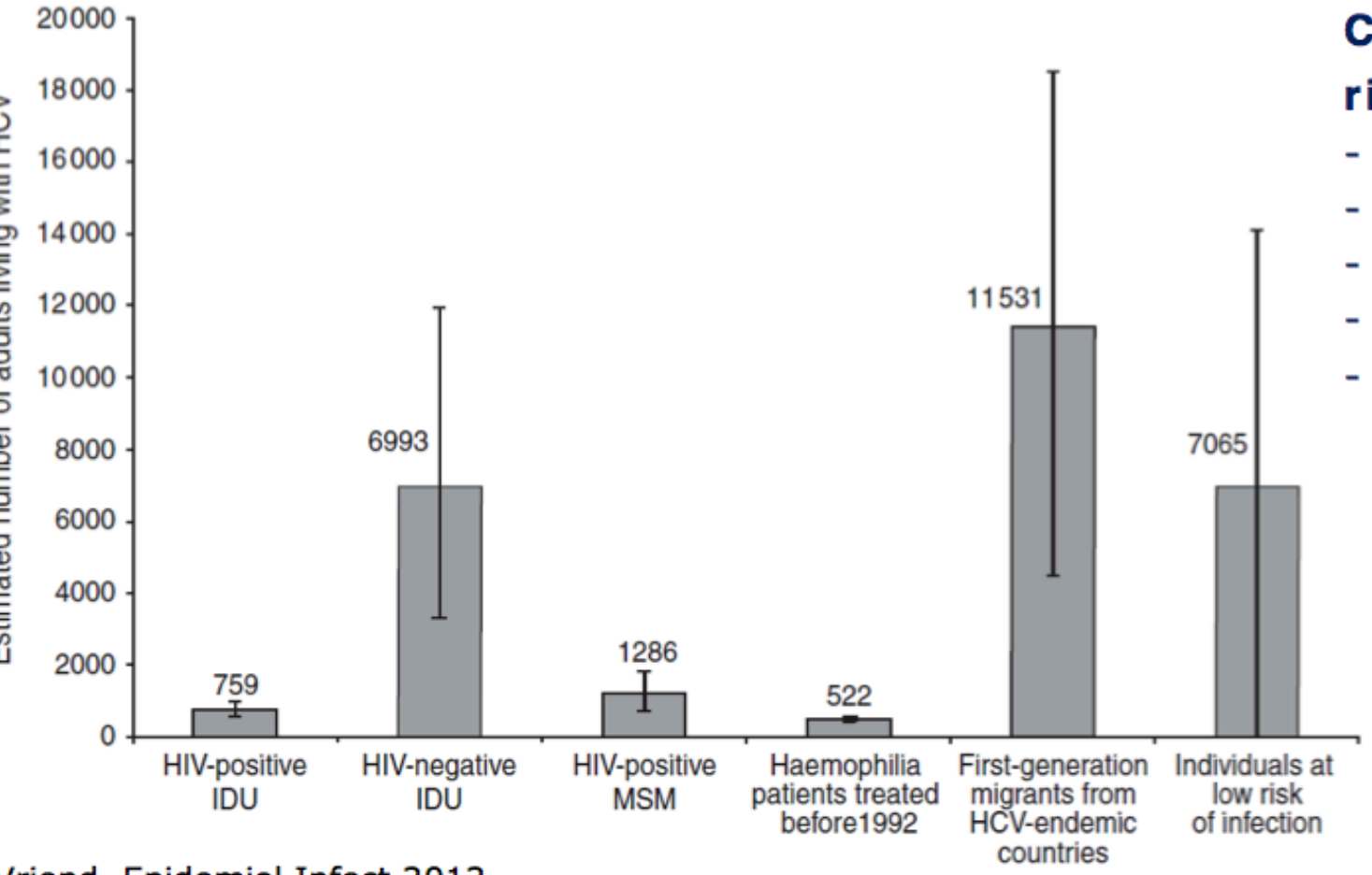
NO….

The real answer is less than 500 steps from here:

- Amsterdam Central Station
- Heroin is a loser’s drug

HCV prevalence in the NL

- Low HCV (0.22%) prevalence
- 28.000 chronic HCV patients



Contribution per risk group

- Migrants	41%
- PWID	28%
- HIV+ MSM	5%
- Haemoph. pt	2%
- Other	25%

Vriend, Epidemiol Infect 2012

HCV incidence in the NL

- Notification data (2015): n=67 (acute infections)
- Route of transmission:
  - unprotected sexual contact among MSM 76%
  - Drug use: 0%

HCV : current practice

Find:

- Migrants: screening projects have a low yield
- Drug users: “Breakthrough” projects, leading to local care paths
- MSM: focus on HIV-pos in treatment
- All risk groups: retrace projects (in registries)

Treat:

- Hepatitis centres all over the country
- >November 2015:DAA treatment is reimbursed for all fibrosis stages, for all patients with a treatment indication, no restrictions regarding route of transmission

National Hepatitis Plan

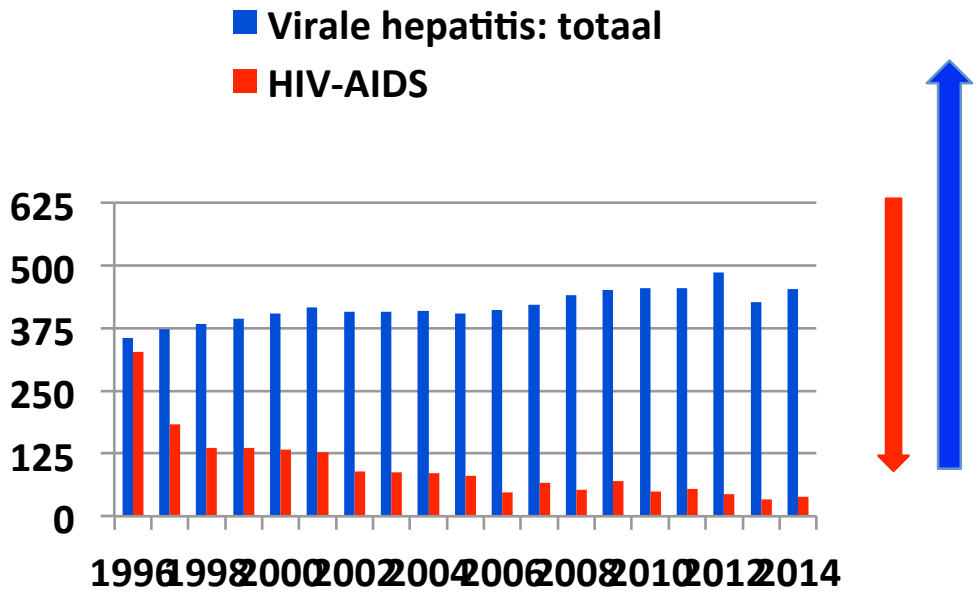
- Title: “More than finding cases”
- Subtitle: “A strategy for action”
- Five pillars
  1. prevent virus transmission through *awareness and vaccination*
  2. timely *identify* chronic carriers through active screening
  3. make widely available diagnostics and adequate treatment (including treatment as prevention)
  4. organise an efficient chain of care
  5. surveillance of disease parameters (incid/preval) and formulate a knowledge agenda

Health Council: advice on screening

- Nationwide screening is not indicated (prevalence too low)
- Screening is recommended for specific risk groups:
  - Migrants from high endemic countries (>2% prevalence in country of origin): regional projects
  - Drug users who injected once or regularly: in addiction care and other places (welfare centres, penitentiary institutions
  - HIV pos MSM: during HIV treatment; also consider screening HIV neg MSM with risk behaviour!
  - Health care staff in contact with patients at risk or who may transmit HCV themselves
  - Refugees: screening during admission procedure, provided that treatment can be offered
- Retracing is recommended

Reasons for HCV treatment

- **Mortality**:



- **Screening** of (I)DUs is cost-effective: With every 1,6 tests 1 HCV case is found; substantially higher than in other risk groups (Kretzschmar 2004) (Helsper, 2011)
- **Treatment** of (I)DUs is as expensive as of non-DU

How to reach elimination?

- Modelling study with projections for 2030, with different treatment scenarios:
  - No changes in treatment:
    - HCV prevalence: decrease by 45%
    - HCC and liver-related deaths: decrease by 19% and 27%
  - Increased efficacy, treatment uptake and diagnosis:
    - HCV prevalence: decrease by 85%
    - HCC and liver-related deaths: decrease by 67% and 65%

- C1/ Already successful treatment structure plus low incidence
- C2/ For elimination around 2030: screening + prevention + treatment required
- C3/ Most feasible: Scale up treatment

Source: Willemse et al, 2015

Conclusions

- To eliminate HCV, we have to increase screening efforts in risk groups and build capacity for treatment
- Challenges:
  - find patients not in contact with the health system
  - Optimise the chain of care
  - Increase finding and treatment in prison population