Master of Public Health

Master international de Santé Publique

Reduction of hepatitis C among Intravenous Drug Users

The feasibility study of a Harm Reduction program, targeting the entry into the injection: "Break the Cycle"

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LIST OF ACRONYMS

AAH	Allocation Adultes Handicapés - Allowance for Disabled Adults
AAI	Accompagnement A l'Injection - Accompanying the injection
AFP	Agence France Presse
AIDS	Acquired Immune Deficiency Syndrome
APOTHICOM	Association pour la Prévention, la Pharmacovigilance et la Communication
	Association for the Prevention, pharmacovigilance and Communication
CAARUD	Centre d'Accueil et d'Accompagnement à la Réduction des risques pour les Usagers de Drogues
	Welcome Centers and Support in Harm Reduction for Drug Users
CAP	Certificat d'Aptitude Professionnelle - Certificate of Professional Competence
CCAA	Centre de Cure Ambulatoire en Alcoologie - Center Outpatient Alcoholism Treatment
CILDT	Centre Intercommunal de Lutte contre les Drogues et la Toxicomanie
	Council Intercommunal fight against drugs and drug addiction
CMU	Couverture Maladie Universelle - Universal Health Coverage
CSAPA	Centre de Soins d'Accompagnement et de Prévention en Addictologie
	Care Centers of Supporting and Prevention in Addiction
CSST	Centre de Soins Spécifiques pour Toxicomanes - Specialized Care Centers for Drug Addicts
DU	Drugs Users
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ERLI	Education aux Risques Liés à l'Injection - Education to the risks associated with injection
ESCAPAD	Enquête sur la Santé et les Consommations lors de l'Appel de Préparation A la Défense
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU	European Union
GHB	Gamma Hydro Butyrique (acid)
HBD	High Dosage Buprenorphine
HBSC	Health Behaviour in School-aged Children
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HR	Harm Reduction
IDU	Intravenous Drugs Users
INPES	Insitut National de Prévention et d'Education pour la Santé
	National Institute for Prevention and Health Education
INSERM	Institut National de la Santé et de la Recherche Médicale –
	National Institute of Health and Medical Research
INVS	Institut National de Veille Sanitaire - National Institute of Health Surveillance
NEP	Needle Exchange Program
NGO	Non Gouvernemental Organisation
OFDT	Observatoire Français des Drogues et Toxicomanie
	French Observatory for Drugs and Drug Addiction
PDU	Problem Drugs Users
RMI	Revenu Minimum d'Insertion - Minimum Revenue for Insertion
UNODC	United Nations Office on Drugs and Crime

PART 1/ CONTEXT

A. The intravenous use of drugs and the transmission of Hepatitis C in France

Drugs means “psychoactive substances*" that act on the psyche. Drugs began to be consumed in a search of fun from the 19th century. From a legal standpoint, they are classified according to their character lawful* or unlawful*.[1]

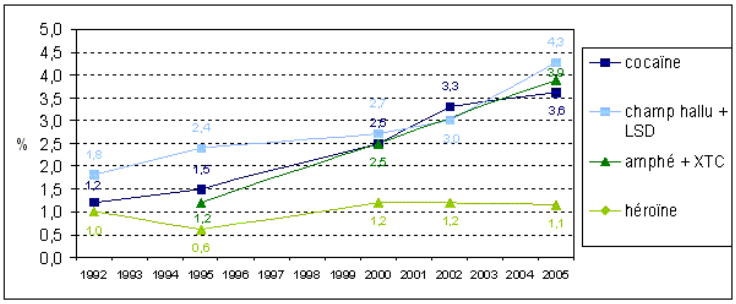
Drugs in circulation and estimates of their consumption in the general population

It should be noted that available drugs are constantly evolving. In France, in 2009, according to the Observatoire Français des Drogues et Toxicomanie (OFDT), the main drugs consumed and/or in circulation at variable frequency are: [2]

- the opiates* that are "central nervous system depressants*”: heroin, diverted substitute treatment for opiates (High Dosage Buprenorphine (Subutex® or HDB), methadone, morphine sulphate (Skenan) and codeine) and Rachacha
- the "stimulators of the central nervous system*": cocaine including crack or free base or cocaine base*, amphetamine and methamphetamine including ecstasy
- the "disruptors of the central nervous system *" (or hallucinogenic): mushrooms, LSD
- ketamine, Gamma Hydro Butyrique acid (GHB), poppers, cannabis and diverted psychotropic drugs

The drugs consumption data for France come from the 2005 *Health Barometer* from the Institut National de Prévention et d’Education pour la Santé (INPES) whose surveys have been done in the French general population. Thus, as shown in the table below, more than 3% of 18-44 year-olds has experimented with cocaine and hallucinogenic mushrooms while 1% has tried heroin. Regular consumption of these drugs relates primarily men. [3]

Use during the life of psychoactive substances (excluding alcohol, tobacco and cannabis) among the 18-44 age

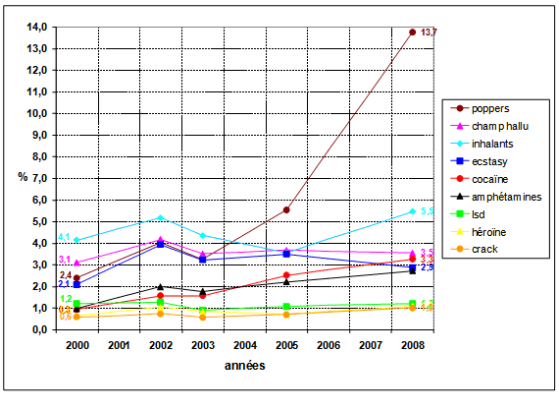


Sources : Baromètres Santé 1992-1995-2000-2005, INPES exploitation OFDT ; EROPP 2002, OFDT

[1] CENTRE QUEBECOIS DE LUTTE AUX DEPENDANCES. Drogues, savoir plus, risquer moins. Le livre d’information, 2006
[2] CADET-TAIROU A, GANDILHOU M, LAHAIE E, CHALUMEAU M, COQUELIN A, TOUFIK A. Drogues et usages de drogues en France. Etat des lieux et tendances récentes 2007-2009. Neuvième édition du rapport national du dispositif TREND (Tendances Récentes et Nouvelles Drogues).OFDT, Saint Denis, 2010
[3] BECK F, GUILBERT P, GAUTIER A ; Baromètre Santé 2005. INPES, 2007 (Enquête chez les 18-75 ans sur les attitudes et comportements de santé réalisée régulièrement depuis 1992 par l’Inpes)

According to the *European School Survey Project on Alcohol and Other Drugs* (ESPAD) conducted by the European Union (EU) in 2008 and the *Health Behaviour in School-aged Children* (HBSC) *survey* conducted by WHO, 5% of 17 year olds has experimented poppers, mushrooms, ecstasy, amphetamines and cocaine. The consumption of these drugs is more prevalent among miners from privileged family backgrounds. It is not the case with heroin.[4] According to the *Enquête sur la Santé et les Consommations lors de l'Appel de Préparation A la Défense* (ESCAPAD) of OFDT, as shown in the table below, between 2005 and 2008, among 17 year olds, experimentations of cocaine and heroin appear to have increased. A difficult school career seems to favor consumption of cocaine and ecstasy. [5]

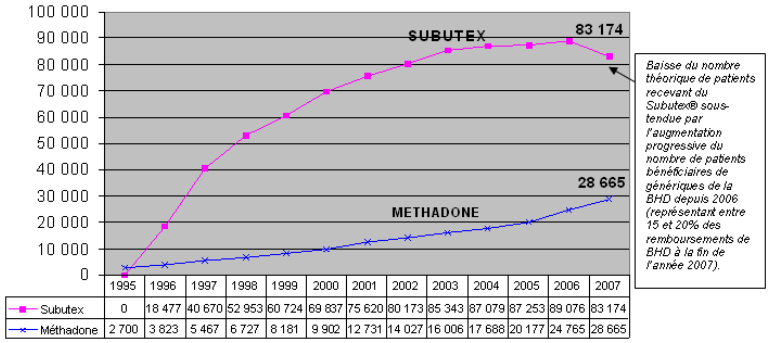
Use during the life of psychoactive substances (excluding alcohol, tobacco and cannabis) among people aged 17



Sources : ESCAPAD 2000-2002-2003-2005-2008, OFDT

According to OFDT, the spread of cocaine as crack or free base seems to have stalled in recent years while the heroine seems to have spread within a public more inserted socially. The HDB is becoming increasingly available on illicit market even if the consumption of this drug is most often framed by a prescription in the context of taking a substitute treatment for opiates*.[6]

Estimated number of people receiving substitution treatment (8 mg Subutex ®, methadone 60 mg)



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Subutex	0	18 477	40 670	52 953	60 724	69 837	75 620	80 173	85 343	87 079	87 253	89 076	83 174
Méthadone	2 700	3 823	5 467	6 727	8 181	9 902	12 731	14 027	16 006	17 688	20 177	24 765	28 665

[Source : GERS/SIAMOIS/InVS]

[4] HIBELL B, Guttormsson U, Ahlström S, Balakireva O, Bjarnason T, Kokkevi A, Kraus L. The 2007 ESPAD Report. Substance Use Among Students in 35 European Countries. CAN, EMCDDA, Pompidou Group, 2009 (enquêtes auprès d'adolescents de 16 ans réalisées en milieu scolaire dans 35 pays européens)

[5] LEGLEYE S, SPILKA S, LE NEZET O, LAFFITEAU C. Les drogues à 17 ans. Résultats de l'enquête ESCAPAD 2008. OFDT. *Tendances*. 2009 (enquête menée auprès des adolescents des 2 sexes âgés de 17 ans lors des journées d'appel de préparation à la défense)

[6] COSTES JM. Les usages de drogues illicites en France depuis 1999 vus au travers du dispositif TREND. OFDT, Saint Denis, 2010

The different modes of administration and use of drugs

The modes of administration* used for each drugs are constantly evolving and depend on their composition, quality and the effect desired by the user. Today, according to these factors, drugs can be ingested*, snorted*, inhaled*, smoked, absorbed through skin or mucosal surfaces (gums, rectum Gold genitalia) and injected by subcutaneous* or intravenous or intramuscular route*.[7]

The method of intravenous injection is made using a set of essential tools. This set of tools called “preparation material for injection” includes the syringe, the needle, sterile water which allows to dissolve the drug, dilute acid (for some drugs only), container (also known as "cup") used to mix the drugs with water and heat the mixture, filter to filter the solution and remove insoluble particles, alcohol buffer to disinfect skin before injection, dry buffer to squeeze veins properly after the injection and the tourniquet used to compress veins upstream of the point chosen for injection.[8]

The use of drugs can be experimental*, occasional* and recreational* without evolving towards a regular and harmful use* (abuse) where repetition may induce a set of damages (physical, psycho, social, etc.) for the subject and his environment. It is worth noting that the injection practice appears to be most often included in regular use even though it seems increasingly evolve into other forms of practice, experimental or recreational in France.[9]

The prevalence of regular injection practice is one of the characteristics of this study’s group of interest, defined as Problem Drugs Users (PDU). This terminology has been introduced by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and replaces the term "addict”. Problem Drugs Users are defined as “injecting drugs and/or long duration and/or regular user of opiates, cocaine and / or amphetamines during the past year for the group of age 15-64 years old". [10]

Profile of Problem Drugs Users

According to the last *World Drug Report* of United Nations Office on Drugs and Crime (UNODC), in 2006, there were 25 million Problem Drugs Users worldwide (or 0.6% of world population aged 15 to 64). Globally, 15.6 million users consume opiates (0.4%) including 11.1 million of heroin (0.3%). 14.3 million used cocaine (0.3%). [11]

[7] CENTRE QUEBECOIS DE LUTTE AUX DEPENDANCES. Drogues, savoir plus, risquer moins. Le livre d’information, 2006
[8] INPES, CRIPS. Réduire les risques infectieux chez les usagers de drogues par voie intraveineuse. 2009
[9] VELEA D. *Toxicomanie et conduites addictives*. Heure De France. Guides Professionnels de santé mentale. 2005
[10] COSTES JM. Prévalence de l’usage problématique de drogues en France : estimations 2006. OFDT. *Tendances*. 2009
[11] UNODC. Rapport Mondial sur les Drogues 2010. Résumé Analytique. 2010

EMCDDA estimates the number of Problem Users of opiates to about 1.35 million people within the EU and most of them are heroin addicts.[12] In France in 2009, OFDT counted 230 000 PDU (5.9 Drug Users (DU) per 1 000 inhabitants).[13] Within this population, 80 000 UD (2.1 per thousand) can be considered as active injectors (use during the last month) and 145,000 (3.7 per thousand) would have used the intravenous route at least once in their lifetime. [14] This group is predominantly male, relatively young but is aging. It also includes groups with psychiatric disorders, living in high social precariousness and coming from the city centers. Most are poly drug use* [15]

Again according to the results of OFDT studies in 2008, a large proportion of the audience of front-line structures* is considered as PDU with a high consumption of opiates.[16] A user over two consumes cocaine powder or injection. The audience is mostly male, except within the group of people under 25 years, where women are the majority and are mostly in a relationship.[17]

Prevalence of injection practice

According to the latest *2010 Annual Report* of EMCDDA, in 2008, the intravenous route remains a central element of the drug problem in Europe and remains the consumption pattern most common among opiates users.[18] In France, according to OFDT in 2006, the number of DU is estimated between 170 000 and 190 000 and a little over half appear to be active injectors. [19] However, data on the injectors in general population are incomplete, partly because the consumption intravenously is marginal and because users are affected by precariousness and are far from public services. The intravenous route is used mainly for the consumption of opiates as well, such as heroin and diverted substitute drugs such as HDB and morphine sulphate. Cocaine as free base is also used intravenously. However, no figures have been produced on the prevalence of intravenous practice for each drug.[20]

[12] OEDT. Rapport annuel 2010: l'état du phénomène de la drogue en Europe. Office des publications de l'Union européenne, 2010
[13] OFDT. Drogues, Chiffres Clés. 3ème édition. OFDT, Saint Denis, 2010
[14] JAUFFRET-ROUSTIDE M, COUTURIER E, LE STRAT Y, BARIN F, EMMANUELLI, et coll. Estimation de la séroprévalence du VIH et du VHC et profils des usagers de drogues en France. Etude InVS-ANRS Coquelicot, 2004. *BEH* 2006
[15] TOUFIK A, CADET-TAIROU A, JANSSEN E, GANDILHON M. Profils, pratiques des usagers de drogues ENA-CAARUD. Résultats de l'enquête nationale 2006 réalisée auprès des « usagers » des Centres d'Accueil et d'Accompagnement à la Réduction des Risques. *TREND*. OFDT. 2008
[16] CHALUMEAU M. Les CAARUD en 2008: analyse nationale des rapports d'activité ASA-CAARUD. OFDT, *Focus*, 2010
[17] PALLE C, VAISSADE L. Premiers résultats nationaux de l'enquête RECAP. Les personnes prises en charge dans les CSST et les CCAA en 2005. *Tendances* 2007
[18] OEDT (OBSERVATOIRE EUROPEEN DES DROGUES ET TOXICOMANIES). Communiqué de l'agence sur les drogues de l'UE à Lisbonne. Rapport annuel 2010: Répondre au problème de la drogue. 2010
[19] Ibid. 14
[20] CADET-TAIROU A, GANDILHOU M, LAHAIE E, CHALUMEAU M, COQUELIN A, TOUFIK A. Drogues et usages de drogues en France. Etat des lieux et tendances récentes 2007-2009. Neuvième édition du rapport national du dispositif TREND.OFDT, Saint Denis, 2010

According to surveys conducted by OFDT within French proximity structures and in care centers in 2008, injecting over the past month was practiced by 46% of users of the Centre d'Accueil et d'Accompagnement à la Réduction des Risques pour les Usagers de Drogues (CAARUD) and 16% of the Centre de Soins, d'Accompagnement et de Prévention en Addictologie (CSAPA). Furthermore, in these structures, the injection has been used at least once in life by 64.4% of those welcomed. [21]

Use of Drugs by Intravenous: risk factors and consequences

Risk factors for transition to injection [22]

The entry into the injection or "initiation" refers to "inject at least a first time", without necessarily adopting this practice on a longer duration. Data in literature show conflicting results regarding risk factors, probably related to the complexity of the phenomenon. Unscheduled first injections are highlighted by several studies but are still debated. The first injection tends to be rather performed by someone else (friend, acquaintance or sexual partner etc.) but there is a new trend for initiation alone. Finally, very little research exists on the profile of people likely to become regular injectors. However, a study shows that among the experimenters with injection, only 12% evolve in a regular practice even though initial experience appears to increase the likelihood of subsequent injection.[23]

Influence of social and environmental context

According to data from literature, school dropout and absenteeism, violence and fugues seem to favor the entry into the injection, as well as parental divorce, physical violence, sex abuse and forced institutionalization. A psychotropic drug abuse by parents is more often observed among injectors. A sexual partner, a friend who injects himself or the attendance of persons injecting themselves within the environment, are also positive factors conducive to entering into the injection. Also according to literature, witness scenes of regular injection, speeches extolling the virtues and pleasures of this practice, being shown how to inject and being supplied could also encourage the entry into the injection. The availability, quality and variation of product costs also appear to push some users in this direction. Thus, the middle of the street and some neighborhoods provided by drugs may contribute to a process of desensitization* of the injection.

[21] Ibid. 16
[22] BELLO PY, BEN LAKHDAR C, CARRIERI MP, COSTES JM, COUZIGOU P, DUBOIS-ARBER F, GUICHARD A, JAUFFRET-ROUSTIDE M, LE NAOUR G, LUCIDARME D, MICHEL L, POLOMENI P, REMY AJ, SIMMAT-DURAND L. Réduction des risques infectieux chez les usagers de drogues. Expertise Collective. INSERM, 2010, page 133
[23] Ibid. 22, page 138

Psychosocial risk factors

According to some studies, pleasure and seeking a greater effect (“taste the flash*") count among reasons for the transition to injection. Other studies show that risk of initiation to injection appears to decrease significantly with age. Users who start drugs use without injection before age 18 are more likely to experiment this practice one day, even though several studies disqualify this finding. According to literature, women who use heroin by other means are less likely to switch to injection than men. However a study in Montreal showed that adolescents are more likely to go to injection when their friends inject themselves, while this relationship is not significant for boys. Precariousness, prison or troubles with the law at an early age also appear to promote entry into the injection.

Social harm associated with injection

Social precariousness

In 2008, according to OFDT, among users of proximity structures expressing a housing problem (49.3%), 60% are homeless or are living in squats. 51.7% of the public are receiving the Revenu Minimum d’Insertion (RMI) or Allocation Adultes Handicapés (AAH) and a quarter have no income. 50.2% are affiliated with health insurance through the Couverture Maladie Universelle (CMU). The majority (63.6%) has reached a Certificat d’Aptitude Professionnelle (CAP). 11% have no identity papers. An audience of "young wandering" without any institutional support (mostly aged less than 25 years) and migrants from Eastern Europe are two groups of population more and more visible, living in social precariousness, remote from health system and within prevalence of injection is pretty high. [24]

Legal consequences

Troubles with the law are very common among illicit drug users especially, group where the practice of injection is quite common. In 2008, 38% of people supported in specialized care centers have experienced incarceration. An episode of incarceration in the year concerns 17.4% of people from services of harm reduction and seems to touch more men (19.9% against 8.7% women). It should be noted that one of the major obstacles to take the sterile equipment by users in structures is fear of being arrested in possession of this material by the police. [25]

[24] Ibid. 16
[25] Ibid. 22, page 50 - 52

Contamination by Hepatitis C Virus

Current knowledge of the health status of Drugs Users depends partly on public health priorities set by the Ministry of Health. Thus, infectious diseases related to the Human Immunodeficiency Virus (HIV) and Hepatitis C Virus (HCV) and their risk factors in relation to the practice of injection are well known. However, it should be noted that injectors are exposed to other somatic damages for which they seem more concerned such as the state of their veins, risk of abscesses, skin and teeth problems.[26] In addition, comorbid psychiatric and psychological symptoms associated appear frequently in the public. [27]

To return to Hepatitis C Virus, while conclusive results are observed in reducing HIV this last decade, HCV infection continues to spread among Intravenous Drugs Users (IDU) and is still considered as a heavy consequence of drug consumption by injection. Obviously, programs and interventions developed in the objective of reducing infectious risk among IDU in France have proven its positive impact in reducing HIV among DU but do not show as effective in stemming the epidemic of HCV.[28] The major source of contamination for HCV is to share the items of preparation material for injection.[29] Thus, *"the process of reduction of infection most effective is based on the systematic use of all components of the injection equipment, sterile, disposable and individually."* [30] [31]

Definition

Hepatitis C is an infectious, potentially fatal disease. It is transmitted primarily through blood. The phase known as "acute" is the phase of contact between the body and the virus and is most often asymptomatic. Beyond 6 months and in absence of treatment, the disease can evolve into a form chronic and concerns about 66% of those infected. Available treatments (Interférons and Ribavirine) aim at neutralizing the virus evolution and are administered either by injection or by subcutaneous capsules. Side effects are particularly important at psychological level. 55% of those treated, heal. [32]

[26] Ibid. 22, p50
[27] A survey conducted by OFDT in 2005 shows that 24% of users surveyed had made a suicide attempt. In 2008, 38% of users had gone to hospital and 24.4% of them by reason of mental disease
[28] BENSLIMANE M, MICHEL L, CHERRIH B, ROBINET S, BODENEZ P, CALDERON C, CAER Y. Hépatite C & Usagers de drogues. Hors - series n°4 Vol. 2. *Le Flyer*. 2007, 44p
[29] JAUFFRET-ROUSTIDE M, LE STRAT Y, COUTURIER E, THIERRY D, RONDY M, et coll. A national cross-sectional study among Drug-users in France: Epidemiology of HCV and highlight on practical and statistical aspects of the design. *BMC Infectious Diseases* 2009
[30] INPES, CRIPS. Réduire les risques infectieux chez les usagers de drogues par voie intraveineuse. 2009 (note DGS/DS2 n° 15/02 du 21/11/1997)
[31] Ibid. 28
[32] INPES. Hépatite C, du dépistage au traitement. Questions et réponses à l'usage des patients. 2007

State of the epidemic

It is estimated that 3% of population worldwide are carriers of HCV, while EU considers more than one million. In 2004, 0.84% of French people between 18 and 80 years have anti-HCV positive. Of the 5000 new cases of hepatitis C each year, about 70% are related to drug use. [33] In France, 53% of injectors for over two years are infected with HCV. [34]

The survey *Coquelicot* conducted by the Institut National de Veille Sanitaire (INVS) between 2004 and 2007 in France among 1462 drug users shows that 60% were infected with HCV and 30% were under 30 years while 11% were infected with HIV. The people with HIV were 100% co-infected HCV and HIV. Paris and Marseille were the cities most affected by HCV. [35]

Significant risk for transmission: situations of lack and sharing equipment[36]

IDU tend to combine several risk factors specific to the transmission of the disease (insecure, excessive drinking etc.) which is being added to the practice of injection itself at high risk.[37]

Knowing that contamination is possible when the blood of an infected person is in contact with the blood of an uninfected person, any contaminated materials reusable and improperly sterilized can transmit HCV. In addition, hepatitis C virus present in the drops of blood (not dried) arranged on various tools of injections can survive longer in air, as HIV. The sharing of injecting equipment is a major vector of transmission. According to the *Coquelicot* survey of INVS, 42% of users surveyed did not know fully the risks associated with use of unclean material for injection. According to OFDT in 2008, within the French proximity structures, 25% of users reported having shared a part of preparation equipment for injection in the past month. [38]

According to data from literature, some situations are conducive to lack and sharing equipment. First, the needle exchange and sterile equipment for injection is not allowed in prisons. Thus, HCV is spreading increasingly among inmates DU. Moreover, compulsive behaviors more and more euphoric generated by the injection of cocaine (free base), may prompt users to chain sessions, leading to faster exhaustion of the clean equipment for injection and promote the sharing situations. Injection of cocaine increased in recent years.

[33] WIESSING L, HEDRICH D, TAYLOR C, GRIFFITHS P. Hépatite C : une épidémie silencieuse. Objectif Drogues. Briefing bimestriel de l'Observatoire Européen des Drogues et des Toxicomanies. EMCDDA. Office des publications officielles des Communautés Européennes. 2003

[34] MDM. Dossier de presse: épidémie d'hépatite C chez les usagers de drogue. 2009

[35] INVS. Enquête Coquelicot 2004-2007. Résultats d'une enquête sur l'hépatite C, le VIH et les pratiques à risques chez les consommateurs de drogues. 2008

[36] Ibid. 22

[37] Le dossier de presse de MDM montre que la prévalence au VHC est multipliée par cinq pour les personnes vivant en situation de grande précarité

[38] Ibid. 35

Precariousness also seems to encourage this sharing. Injection practices and collective sessions of injection in unhealthy places (cars, parks and stairwells) often made in haste and restarted, leading to a lack of clean material, are often cited. Unscheduled consumptions, frequent in the party scene* are also at risk.

The situation of dependence between individuals for the provision of drugs may also push to share material for injection. It should be noted that couple status pushes the sharing of equipment also. Finally, initiation to injection is a major situation of sharing equipment and drugs and seems to concern women and younger people especially.[39]

These situations, where equipment sharing is frequent, are often experienced by young people and by women (in couple, dependence for the provision of drugs and initiation to injection made by the partner are frequent). Add to this, precariousness which is spreading increasingly among this group (the group of homeless people cited above), is another risk factor of contamination. [40]

B. What strategy to reduce the risk of HCV transmission among IDU in France?

*Harm Reduction**

Definition

In his book *Prévention des Toxicomanies, aspects théoriques et méthodologiques*, Pierre Brisson involves Harm Reduction as part of preventive interventions. According to him, this type of interventions revolves around three approaches: reducing the supply and demand, health promotion and Harm Reduction (HR). The approach of HR was born in Europe in the mid 80s in the context of Acquired Immune Deficiency Syndrome (AIDS) epidemic, which had generated an urgent need to address consequences of drugs use. At this time, the message was *"If you cannot prevent you from taking drugs, trying to sniff rather than inject yourself. Otherwise, use a clean needle. Otherwise, reuse yours. At worst, if you share a needle, clean it with bleach".* This pragmatic approach breaks with the desire to eradicate drugs, promotes the "extent" rather than “abstinence” and exceeds a moral view of the drugs. It seeks to reduce the risks (health, economic, social, relational, legal, etc.) to which users are potentially exposed by their practice.[41]

[39] INPES. Hépatite C, du dépistage au traitement. Questions et réponses à l’usage des patients. 2007
[40] Ibid. 35
[41] Ibid. 22

Legal Framework

The birth of Harm Reduction in France is marked by the decree of May 13th, 1987 which allows free sale of syringes in pharmacies for adults. The opening of the first Needle Exchange Program (NEP) was held in 1990 by the Non Governmental Organization (NGO), Doctors of the World. In 1994, Simone Veil provides a framework to prevent HIV and hepatitis and allow users to access the health care system without requiring them to renounce the use. The following two years, the sale of prevention kits, syringe exchange and the two substitute treatments for opiates spread. The Act of August 9th, 2004 gives a more permanent status to HR in stating the state as responsible of its definition. The National Repository of shares of HR of 2005 outlined the objectives and modalities of intervention and makes legal, actions in that context.[42] The Circular of January 2nd, 2006 marked the creation of CAARUD while CSAPA were created in 2007 (combined Centres de Soins Spécifiques pour Toxicomanes (CSST) and Centres de Cure Ambulatoire en Alcoologie (CCAA)).[43]

HR French validated interventions and tools

Access to sterile equipment of HR is well developed in France. NEP and distribution of prevention kits (steribox*) in pharmacies, robots and associations have been assessed by scientific organizations and have proven efficiency, especially in reduction of HIV transmission. Substitute treatments for opiates are widely available especially HDB, even though the diversion of these products may create other risks to consider. Many brochures were created on risks of infection and their distribution is fairly widespread. However, the adaptation of these existing interventions is now needed to respond more effectively to the epidemic of HCV.[44]

French programs under consideration

Distributions of sterile straws for snorting and aluminum foil to inhale the vapors of heroin (this method is called "chasing the dragon*") are experienced marginally in France and raise many questions among HR actors. No scientific assessment has been taken so far, to verify the efficiency of these tools in reduction of HCV. Other tools like a movie *17'10* showing the stages of an injection session and an “artificial arm” to teach workers and injectors how to inject at low risk have been created by the Centre Intercommunal de Lutte contre les Drogues et Toxicomanies (CILDT) and the Association pour la Prévention, la pharmacovigilance et la Communication (APOTHICOM). [45] Their use is still marginal to date and have not been evaluated scientifically neither. Discussion forums on the Internet have also been established.

[42] Annexe 1
[43] Ibid. 22
[44] Ibid. 22
[45] BONNET M, SAYAG L. Panorama des outils développés en France. 2010 (Présentation orale réalisée lors du séminaire de l’INPES du 15 mars 2010 intitulé : « Injection : comment articuler prévention, éducation et réduction des risques », UICP Espace George Stephenson, Paris)

A program aiming at educating users to injection practice at low risk and targeting the reduction of risks associated (*ERLI* program funded by Doctor of the World), a program aiming at accompanying users in their injection practice (*AAI* program funded by AIDES) and a project aiming at distributing "crack pipes" are experimented in France marginally.[46] The *ERLI* and *AAI* programs raise numerous questions on the role played by the workers of the program (professionals, ex-users or users) as accompanying the act of injection in the real situation with the user. They are currently being assessed scientifically by INSERM to verify their impact in reducing the risk of HCV.

State of the partnership and positions of HR actors in France

Nowadays, Harm Reduction approach is debated in France over the place given to moral issues, policies, legislation and above all, to the prevention within its system. In his book *Prévention des toxicomanies, aspects théoriques et méthodologiques*, Pierre Brisson shows that from his earliest years, HR has attached great importance to the work of community workers and street work, while *"the integration of traditional practices of prevention and health promotion was more difficult".* This author defines "prevention" as *"a set of measure implemented to prevent the occurrence of an undesirable event".*[47]

Today, the landscape of HR network is dominated by advocacy groups, representatives of users or self-support groups* created at the time of the AIDS epidemic in the 80s. These organisations are still struggling to get their legitimacy. In addition, many semantic, political and maybe "ideological" blockages disconnected from any scientific approach stunt coordinated implementation of innovative strategies.

These self-support groups defend arduously original and fundamental HR principles that must guarantee above all, recognition and respect for desires and chosen lifestyles of users. These stakeholders argue their position by the necessity to respect the choices of the person including the pursuit of pleasure in drugs consumption and put forward the idea *"that the drug is primarily a lifestyle choice".* Decision makers of these groups therefore, ensure that any new intervention is not contrary to these values and that it does not stigmatize users (here the injector) or practice (injection) or more largely drug consumption.

[46] JAUFFRET-ROUSTIDE M, RONDY M, OUDAYA L, GUIBERT G, SEMAILLE C, PEQUART C, coll. Inter-CAARUD sur le crack. Une enquête auprès des consommateurs de crack en Ile-de-France. Retour d'expérience sur un outil de réduction des risques pour limiter la transmission du VIH et des hépatites. *BEH*. 2010

[47] BRISSON P. *Prévention des toxicomanies. Aspects théoriques et méthodologiques*. Presses de l'Université de Montréal. Coll. Paramètres

Their position seems to be intensified by the lack of negotiation and joint decision making on how acting in HR between associations and Ministry of Health, which shows these days, few support in strengthening HR.[48] It may be also linked to the reinforcement of criminal law in drug consumption in France.[49] Yet many political and scientific speeches acknowledge the interest and the need to develop and strengthen these actions.[50] One can hypothesize that these groups may feel at risk with a government little voluntary (debate on consumption rooms etc.) and therefore argue for their "survival".

Thus, current French interventions for reducing HCV among IDU are implemented mainly by these associations and act first in the objective of limiting potential damages generated by a “chosen” practice or by the product consumed, without discussion or revive questioned his desire to consume or use this specific practice. Interventions privileged today are based on it and within a situation of consumption, rather than within the phase preceding a possible entry into the consumption. Interventions don’t aim at “avoiding” (preventing) a transition to the practice of injection neither. Indeed, as *"a measure of anticipation to prevent an undesirable state or an event’s occurrence",* one can hypothesizes "prevention" may be seen as contrary to HR principles. *"Act proactively to prevent an event occurring"* (here potentially drug use, injection etc.) by trying to "block" the lifestyle's occurrence that is potentially wanted by the user, may be seen as contrary to the main HR value. Moreover, the negative qualification *"adverse event"* (here drug use, injection practice etc.) may be also seen as judgmental about the lifestyle’s choice of the individual, also contrary to HR principles.

However, these actors recognize the character at high risk of infection of the practice of injection and the initiation phase to injection. They therefore agree to support potential new interventions to prevent HCV infection, but bias that may consist in "limiting injection practices” (reducing incidence and prevalence) would be discussed. Indeed, they tend to think, that "intervene" to "try to avoid" can be likened to forms of social control.

In France, scientific organizations are associated to the debate on HCV reduction among IDU but marginally. Some (not all) existing HR interventions in France focusing on education to lower risks in a regular practice of injection are currently assessed by scientific organizations such as INVS. Regarding the perspective of a strategy targeting the entry into the injection, scientists don’t have necessarily the leadership on decisions to date.

[48] Annexe 2
[49] CONSEIL NATIONAL DU SIDA. Note valant avis sur l’impact des politiques relatives aux drogues illicites sur la réduction des risques infectieux. 2011
[50] ANRS. Drogues et risques infectieux: de nouvelles stratégies de réduction des risques à l’étude. Communiqué de presse. 2010

However, a scientific committee has just been created by the President of the French HR network. In addition, this new option of strategy has been studied and validated in a collective expertise conducted by the Institut National de la Santé et de la Recherche Médicale (INSERM) in 2010 in the aim of reduction of HCV among IDU, whose results was published in October of that year.

Improvements to reduce risk of HCV: what action in the context of entry into the injection in France?

As briefly mentioned above, the objective of limiting the transmission of HCV among injectors, (current French public health priority) suggests several options in terms of strategy of intervention. The first aims at limiting the risk of infection through an installed and regular injection practice. This option requires that programs are centered on education to injection and the associated risks, coupled with distribution of material and support its use among IDU. Programs in France seem developed under this option in particular. But as seen above, the adaptation of the existing provision is now needed to respond more effectively to the epidemic of HCV.

The second option may consist in reducing the prevalence of injection practice in France (because at higher infectious risk than other practices) by limiting the entry into the injection (reducing the incidence) or by accompanying injectors to the exit of injection (temporarily or permanently) through delivering substitute treatments for opiates or through transition to other modes of administration. This method consists in proposing, informing and supporting the public in the use of alternative practice in consumption, less risky than injecting.[51] The option of limiting the entry into the injection could settle interventions directly targeting potential new injectors (the groups with the characteristics considered "at risk"). Programs could be designed in order to educate the public about consequences of injection, act on psychosocial factors that may lead to enter into the injection or propose alternatives to this mode of administration. With a similar view, the target could be the injectors themselves, potential initiators, to empower them to deal with an application for a first injection and to be able to advance more relevant arguments to the injection seeker.

A last option could be more dedicated to users, determined to start to inject. In this case, the intervention would have to focus on the transmission of advice, gestures and rules for an injection at lower risk. This information could be delivered by peers or by other stakeholders, more likely to be present at the first injection. Currently no working axes around the entry into the injection are developed in France and very little internationally. The only intervention acting on this axis is an English program called *Break the Cycle*.

[51] BRIDGE J. Route transition interventions: potential public health gains from reducing or preventing injecting. *International Journal of Drug Policy*. 2010

A model for intervention: the English Break the Cycle programme

The English program *Break the Cycle* is one of the few models of intervention in the world targeting the entry's phase of the injection to reduce infectious damages for IDU. It is designated as a program of "prevention of transition to injection" but uses a peer-based approach* to reach the non-injectors. It pursues two objectives:

-prevent transition to injecting by approaching injectors, potential initiators and giving them the means to respond to any request from people wishing to inject including talking to the individual of other modes of administration

-reduce the risk linked to the injection practice and accompany users to other modes of administration such as "heroin chasing".[52]

Thus, it provides an integrated approach* with double axis of response for non-injectors and for injectors. It bases its intervention on transition to other modes of administration which has the advantage of being adapted to both injectors (temporarily or permanently) and to non-injectors. This program was presented to the French actors at a seminar organized by INPES titled "*The relationship between prevention, education and risk reduction"* in March 2010.[53] It has raised a strong interest among partners as it emerges from it, new ways of thinking and innovative actions to reduce the HCV epidemic. It has been identified as a promising program in several aspects including in reducing HCV, as part of the expert group conducted by INSERM in 2010. The positive effects of this program in its initial structure were measured in 1998. Since then, it has been experienced in other countries. It shows great flexibility in adapting to specificities of local context, brakes and levers.[54]

[52] JANKOWSKA T, SOUTHWELL M, PICORNIE W. Benefits of Heroin Chasing Campaign as a Harm Reduction Tool. http://www.drugtext.org/articles/jankowska.htm. 2009, 8p

[53] HUNT N. Break the Cycle. Transition vers d'autres modes d'administration. 2010 (Présentation orale réalisée lors du séminaire de l'INPES du 15 mars 2010 intitulé : « Injection : comment articuler prévention, éducation et réduction des risques », UICP Espace George Stephenson, Paris 2010)

[54] GUICHARD A, FOURNIER V, MICHELS D, GUIGNARD R. Réduire le risque d'infection par l'hépatite C chez les usagers de drogues : la piste de la prévention du passage à l'injection. N° 409 – Septembre -Octobre 2010. *La Santé de l'Homme*. INPES. 2010

PART 2/ OBJECTIVES OF THE PROJECT

The public health problem to which this study attempts to answer is the increasing contamination of hepatitis C among drugs users. The goal is to contribute to the containment of the epidemic in this population. This study focuses on the context of the practice of injection and the specific conditions of risk taking in this specific practice. It starts with the assumption that the mode of intravenous administration and the phase of entry into the injection is a significant risk of HCV infection.

Other basic assumptions underlying this study are that the French HR interventions to reduce the risk of infection for IDU show conclusive results in reducing HIV. But contamination with HCV is so far less well known and treated. In addition, these interventions are especially developed for reducing the risk taken in the context of a regular and installed practice. Early intervention towards potential future injectors for reducing the incidence of the injection practice and / or facilitate entry into the injection as secure as possible, is still little experimented to date.

This study seeks to study the feasibility of the implementation of a new strategy in France, based on entry into the injection to achieve more success in reducing infection by HCV. The effectiveness of an intervention around the entry into the injection compared to the reduction of HCV is a premise that has not sought to be checked during investigations. The relationship between efficiency "reduction of HCV among IDU" and "interventions in the context of entry into the injection" will be assessed probably later, after testing this type of intervention in France.

The central question of this project is ***"how and under what conditions can we implement a strategy of interventions targeting entry into the injection in France, to reduce HCV infection among intravenous drugs users"?***

The axis of new interventions may seek to supplement or upgrade those which are existing or experiment new methods of intervention. This reflection must take into account the specificities of French context (values and commitment of all actors, policies, and profiles of IDU, brakes and levers etc.) and must be based on the Harm Reduction approach. The study seeks to test several hypotheses regarding the conditions of implementation of this strategy:

- Interventions targeting the pre and concomitant phase of entry into the injection (or initiation) at high risk of HCV infection can be developed in France under the HR device
- The example of *Break the Cycle* program can be adapted to the French context, but requires numerous conditions

In short, the purpose of this study is to establish guidelines for developing a more effective intervention strategy to reduce HCV among injectors in France. The first objective is to test the feasibility of the implementation of a strategy that relies on the entry into the injection. To this end, this research analyses the *Break the Cycle* program and its adaptability to the French context and especially its integration within the existing supply of HR. Its suitability is analyzed based on the replies given to three questions:

-Are French supply of HR and its network of actors ready to integrate a program focusing partly on "prevention of the entry into the injection?

-Is this program acceptable (in its basic principles) and adaptable to the French context?

-And if so, what forms, conditions and modalities are expected in order to become an integrated tool to supply existing HR?

PART 3 / METHOD, RESULTS

A. Method

Framework of investigations

This study is part of the launch of partnership thinking about a new strategy of intervention and / or the adaptation of existing interventions, as recommended by the Ministry of Health, for addressing the epidemic of HCV among IDU in France. The coordination of this reflection is done by INPES, a prevention and public health agency under the supervision of the Directorate General for Health (Ministry of Health). In addition to the coordination of this reflection, INPES feeds the exchange by providing data on the French context and on the experiments of *Break the Cycle*.

This reflection occurred in a particularly sensitive context of penalization of uses, recall to law and heated debates around consumption rooms. Thus, these first months were dominated by the militant rhetoric even though the beginning of an ideological deconstruction. Then, a reconstruction took over and shows today encouraging results.

Initially, the axis moved by INPES for thinking about a new strategy was *"how to act together in France to prevent the transition to injection among drugs users?"*. However, this proposal has raised strong reactions among French actors, related to the HR principles advocated by self-support groups which tend to generate the rejection of the prevention approach*. It has resulted in changing the area of reflection which became "the entry into the injection". This more global axis includes both "prevention of transition to injection" and "action for an initiation at lower risk" to intervene both towards an audience eager to inject but inclined to change his view and towards those who are determined to begin injection practice.

Alongside the coordination of this partnership reflection, INPES launched an exploratory investigation on “the entry into the injection” at the end of 2010, whose results will come out in fall 2011. In addition, this institution launched a feasibility study for the possible adaptation of *Break the Cycle* to the French context through a feasibility study for the implementation of a new strategy based on entry into the injection. This study started in early 2011 and will probably be finalized by the end of that year. This study was conducted as part of an internship to validate a Master in Public Health. The directorate of INPES in charge of this study is the Directorate of Scientific Affairs. [55]

Investigations during these four first months have targeted the axis associated with entry into the injection (prevention of transition to injection, initiation to injection, the transition to other modes of administration etc.). Data collection did not target specific professional practices to reduce hepatitis C. This document presents the method used and the results found during these first four months of the study.

First step: deepening theoretical knowledge of the subject

Researches in the literature have been conducted as well as readings of reports and book chapters. Several resource centers were contacted. Several journals and websites were consulted. The documentary research was completed by the service documentation of INPES on various websites. The French news on the subject, have been followed through the site Agence France Presse (AFP). Resource persons were requested. Various key words have been used in information retrieval. [56]

Second step: analysis of the adaptation experiences of Break the Cycle internationally

To conduct this study, INPES has thought essential to have a return on the experiences of the implementation of the program *Break the Cycle* in different countries to avoid certain pitfalls and activate levers most relevant as soon as possible. This shared experience also sought to obtain benchmarks and references (good or bad) to eventually adapt the intervention while taking into account specificities of foreign contexts more or less similar to the French characteristics. The objective was to review the different versions of *Break the Cycle* and analyze the conditions for adapting this program in different countries to identify brakes and levers, difficulties and solutions found in different contexts.

[55] http://www.inpes.sante.fr/

[56] Key-words: *drug use in France, the practice of injecting, the risks associated with injection, the entry into the injection, the initiation to injection The prevalence of hepatitis C in France, the risks of transmission of HCV among injectors, Risk Reduction in France, HR interventions in France, interventions for the reduction of HCV among IDUs, the models of intervention in the world on the entry into the injection*

A contact was established with the program manager of *Break the cycle* in order to propose him to accompany INPES in this study. Our expectations were based on providing advices and expertise but also to survey international teams that have implemented the program. Unfortunately, several constraints have hindered the realization of this investigation. The interview and questionnaire method proposed by INPES has not been validated by the program manager who thought more appropriate to centralize information and perform the analysis himself.[57] [58] To preserve this collaboration, INPES has accepted these conditions, aware of the potential conflicts of interests at stake. The study of international experiences of *Break the Cycle* has been realized by him. The method and procedures of the investigation and the number of persons surveyed is unknown to this day. INPES' efforts have shifted towards mobilization of French actors and gathering background information on the French context.

Third step: making contact with the French actors

During these four months, we started to mobilize the major French actors of the HR in order to get an appropriate partnership for a possible future implementation of the program. The aim was therefore to identify and mobilize French HR "headend" and present them our approach. We scheduled with them an initial meeting to introduce *Break the Cycle* in its initial structure, its modified versions in different countries and the results of the analysis of these experiments. An interregional meeting *Hepatitis addiction* was organized in Bordeaux, during which two preliminary non-directive interviews were conducted with French actors on the subject.

Fourth step: data gathering in the French HR structures on entry into the injection

This step aimed at establishing a first contact with structures capable of implementing an eventual intervention around the inlet in the injection. A qualitative census of HR practices in France, representations and expectations of the actors on the different approaches associated to the entry into the injection was conducted in five major cities in France with an investigation by semi-structured interviews, conducted by telephone or face to face. [59]

Specifically, we aimed at collecting a first set of data on the potential brakes and levers to the implementation of interventions on the entry into the injection and those for the adaptation of *Break the Cycle* to the French context. These data were collected, categorized and analyzed using various tools and according to a frame including the main themes associated. [60] This survey was conducted in preparation to the first meeting of the French actors. The results of this survey were presented during this meeting, after the approval of all participants.

[57] Annexe 3
[58] Annexe 4
[59] Annexe 5
[60] Annexe 6

Fifth step: additional data collection as part of the first meeting of the French actors

The purpose of the working group was to bring together key actors, collect their position on the entry into the injection and develop ideas on the conditions for implementing such a strategy. The usefulness of this first meeting was to create the space for a co-construction of this strategy and maybe of *Break the Cycle* program. Rather than directly the cooperative development of the adapted version of this program, the objective was primarily to share experiences, practices and opinions regarding this strategy.[61]

Based on the example of *Break the Cycle* program, another objective was to gain a better shared understanding of the incentives and obstacles to the implementation of this program and start thinking about conditions and modalities of its implementation. To facilitate processing and analysis of data collected during exchanges, the meeting was recorded. Members of this working group were appointed "experts" in the context of INPES.

B. Results of investigations

The results of investigations during these first months confirmed the virtual absence of formalized approach, of evaluation and of generalization of initiatives on the initiation to injection axis. However, these results have led to identification of trends in opinions about conditions for implementing a strategy based on the entry into the injection. It brought us an initial assessment of the hypothetical brakes in France related to this specific strategy. They also allowed for an initial identification of local actors on which to rely for developing it. It brought us an initial assessment of hypothetical brakes and levers in France related to the adaptation of *Break the Cycle* program.

In terms of partnership

As investigations were going on, we observed that the collaborative development of a new strategy of intervention to reduce HCV among IDU was greatly hampered by numerous factors. “Ideological” barriers disconnected from any scientific approach, and issues of power, seemed to impede the progress of a collaborative reflection on this new strategy and especially on its prevention aspect. Thus, the results of investigations revealed progressively a strong need for better articulation and coordination among French actors of HR and a clear consensus between them, around modalities of implementing a strategy around the entry into the injection. Indeed, we observed that the militant rhetoric dominated the discussions and it was probably linked to the current French political context regarding HR. However, the union between actors has been gradually recognized by all, as a prerequisite for progressing in reduction of HCV epidemic among IDU.

[61] Annexe 7

Thus, this shared and common objective and the prospect of a new strategy of actions based on it, has pushed major actors of HR to get together, despite these various brakes and constraints. During these four months, they tried to agree on common principles for the implementation of such a strategy. [62]

Results of the survey in the French structures of HR

Sample

The survey sample is composed as follow:

The director of **a national self-support group**	One HR worker of an **association of community health in the East of France**
The president of **the French network of HR**	The vice-president of **an association of the Party Scene in the east of France**
The vice-president of **a national French HR association**	The director of a **CAARUD and CSAPA in north of France**
The coordinator of the **national ERLI program from a French NGO**	Two educators of **a CAARUD in the west of France**
A health educator **from ERLI program**	A health mediator in a **CSAPA in Ile de France**
A pharmacist responsible for **a national network of prevention of addiction** and who intervenes in a **consultation with young consumers in Paris**	A nurse in **a CSAPA in Ile de France**
A physician leader **of a CSAPA and a CAARUD in the south of France** and vice-president of a **federation of French HR actors**	The director of **a CAARUD in the south of France** (shelter for IDU called Sleep In)
The physician responsible for the **sector addiction in the General Directorate for Health (Ministry of Health)**	A public health consultant who is at the same time volunteer in **a self-support group in the south of France**

Prevent the transition to injection and / or act upon the initiation to injection

Overall, those interviewed believe that interventions targeting the entry into the injection are interesting though no specific intervention in this area is currently developed within these structures. It should be noted, however, that actors seem to have more restraints for interventions on the "prevention of transition to injection' than for "initiation to injection at lower risk."

Regarding prevention of transition to injection, most believe, that acting in that sense, first requires a deeper knowledge of the phenomenon in terms of understanding the mechanisms, relationship to drug's use and knowledge on potential initiators. Moreover, the actors are wondering if "prevention is part of the HR" and "how articulate actors of prevention and those of HR".

[62] WIESSING L, HEDRICH D, TAYLOR C, GRIFFITHS P. Hépatite C : une épidémie silencieuse. Objectif Drogues. Briefing bimestriel de l'Observatoire Européen des Drogues et des Toxicomanies. EMCDDA. Office des publications officielles des Communautés Européennes. 2003

The implicit objective of "*deterring a person of entering into the injection and a fortiori, not to respect his choice*" through the preventive approach, questions the interviewees. A director of a structure underlines the reality of determination among some users to enter the injection and thinks that *"the transition to injection can't be addressed; the meeting with the syringe is done anyway, especially if it has a true desire behind ".* Thus, doubts were expressed about the possibility of integrating actions to prevent a phenomenon within the French HR device.

According to participants, actions aiming at preventing the transition to injection should be integrated into a wider range of tools to avoid an exclusive position and responding to the wide range of profiles and needs among IDU (injectors who want to quit injection, non-injectors who want to learn, injectors seeking to take a break from their practice etc.).

According to several participants, "prevent the transition to injection" or intervene "at the time of initiation to injection" requires to be present at that time. Most stress that the presence of the professional is relatively rare at this moment. According to them, peers as well as teams from the party scene, more likely to be present, occupy a central place both on the objective of preventing the transition to the injection and to act for an initiation to injection at lower risk.

A stronger HR action conducted by actors of the party scene and through the "street work" will probably help to extend HR offer to a remote public from the structures (public inserted or in a position of precariousness), eager to inject or already injectors who can initiate others to injection. Finally, overall, interviewees seem more in favor of an intervention towards injectors "*providing them means to initiate others in safest conditions*". Many believe that the urgency in France today is more on the prevention of using unclean injection material and on transmission of advices and information to the beginner.

<u>Propose, support the transition to other modes of administration</u>

The majority believes that this approach is interesting and should be developed in France. However, a number of brakes and conditions have been stated during this survey on the use of this approach. Firstly, the relationship to the injection gesture and the probability that it is "*difficult to go back, when one started and when one injects since a long time*". Secondly, the assumption of a lack of knowledge on different practices in France is another potential barrier. In any case, according to representatives of Ministry of Health, this approach must be integrated into a wider range of tools and stakeholders must be trained to the use of other practices. Several refer to the quality, composition and price of the product making it possible or not. Taking into account local ie territorialize tools and interventions based on lifestyle, practices and particularities of products in circulation in the area is a condition shared by the participants.

Another idea is the close cooperation with users seen as crucial for this approach. The proposed mode of administration must respect the pleasure originally sought by the individual. The acceptability of another mode of administration depends on the condition and expectations of users.

For this approach, the participants think it is more suited to a public whose health condition requires a break in the practice of injection (vein issues, abscesses etc.). Others believe that such a campaign should be delivered to everyone and at any stage of practice (entry, break, exit of the injection). More marginally, interviewees believe that people who have not yet started to inject and those who are already in different practices would be a more receptive audience.

The *Break the Cycle* program

During this investigation and to the surprise of INPES, several initiatives in France, close to the concept developed in the program *Break the Cycle* were presented. Since the submission of *Break the Cycle* at the seminar of INPES, a HR team in Bordeaux had started working on transition to other modes of administration by proposing to users, the method of “heroin chasing”. In Marseille, a representative acting on behalf of a local network of HR and trainer of HR workers is looking for funding to train local teams to the program intervention *Break the Cycle*. These isolated initiatives in Marseille and Bordeaux, without consultation and without common ground confirmed the need for better articulation and coordination between French actors of HR.

Overall, French actors think that the peer approach and the idea of intervening in the context of initiation to injection developed in this program are interesting. However, its original name "preventing transition to injection" appears to slow the validation of its integration into the HR device. According to participants, this program must be integrated into a wider range of tools that would work with various approaches such as education to injection at lower risk, transition to other modes of administration, prevention of transition to injection and actions in favor of an initiation at lower risk.

Results of the analysis of the Break the Cycle experiments in the world

Break the cycle in Australia *(**Queensland**): Break the Cycle* has been imported into this country shortly after its creation. It has been incorporated into the needle exchange program managed by the state. The reasons for the failure of this experiment are around the absence of adaptation of the tools to the local culture (drugs in circulation, practices and habits of the users etc.).

Perceived as stigmatizing, a considerable resistance from drugs user activists, who were not consulted beforehand, has led to failure. Integrate intervention in local culture and fully consult and involve drug user organizations are two major conditions.

Break the Cycle in Central Asian Republics: The implementation of *Break the Cycle* within this region was to curb the escalation in consumption of opiates by injection. The material has been adapted to the local culture and recipients of the intervention have also received training on prevention of overdose. A local program "Youth Power Program" implemented and for young people at risk, was integrated to *Break the Cycle* and social marketing actions on the entry into the injection was broadcast on television. The actual number of initiators has dropped by 50%. It shows the possibility of linking to other interventions and of operating in conjunction with complementary programs e.g. mass media, 'at risk' groups etc.

Break the Cycle in Australia (New South Wales): In 2004, a Program of Prevention to The Transition To Injecting (Potti) was launched in Sydney whose objective was to decrease the HCV by reducing the number of young people who begin to inject. To strengthen the capacity of health professionals to explore the potential role of injectors in the prevention of transition to injection and reducing damage associated, a video was screened in the presence of 267 workers. The tools and material of *Break the Cycle* have been attached to other tools of intervention dedicated to the beginners. Potti is well accepted as a strategy of HR.

Break the Cycle in Albania: The program is funded by UNICEF and coordinated by two NGO. It aims at preventing HIV among injectors. 111 users have received the intervention and 82 are followed-up. The evaluation shows that the rate of "talking about the injection practice in front of non-injectors"and "initiation" have decreased. The intervention was effective in addressing other problems (vein care, hepatitis C, overdose) and to help understand the needs of users. In settings with underdeveloped services, this program can be a trigger to developing responses to other issues.

Break the Cycle in Aberdeen, Scotland: Funding was granted for implementing the program into needle exchange centers. The intervention was conducted among 483 persons and 52 persons are followed. The evaluation shows a reduction in all related behaviors. It is currently being rolled out across Scotland. Its integration into local services is sustainable through its funding and the existence of a leader. It is possible to embed the intervention in services in a sustainable way if the program is properly resourced and someone has clear leadership.

Break the Cycle in South East Europe: Surveys in Bulgaria, Macedonia, Croatia and Bosnia-Herzegovina have showed that the intervention was relevant (injectors were already reluctant to initiate other to injection and social exposure of non-injectors to the practice was common). However, local stakeholders, to whom the program was imposed, have doubted its applicability relating to the transition too fast from "no injection" to "injection". The lack of means has led to focus on harm reduction with people who inject which were seen as a greater priority than prevention of initiation to injection.

Break the cycle in Vietnam: The intervention is aimed primarily at commercial sex workers who are considered as a high risk population. The aim is to counter the perceived benefits of injection and discourage drug users to switch to injection. This version of the program is being evaluated.

Break the Cycle in United-States: The program was established in Denver Colorado and Baltimore and is showing signs of good acceptability among injectors. For Denver, intervention is collective and was assessed by University. For Baltimore, the public appreciated the opportunity to reflect on the circumstances of their first injection and on strategies to avoid promoting injection towards non-injectors. The program aims to sensitize the injector on the potential impact of an injection made in front of a non-injector. Injectors are compensated for their investment in the program and for the role they potentially play towards non-injectors. The first results of the evaluation show a difference between the public who have already decided not to initiate to injection and the younger injectors who tend to convey a glamour effect to the practice among the non-injectors. The action seems more beneficial to younger even if young are reluctant to participate in collective actions. One of the major obstacles was the unauthorized distribution of sterile injection materials in U.S. Initiation is the topic that most interests injectors because few of them were used to discuss of their experiences.

Break the Cycle in Toronto: This version is called "Change the Cycle" and is based on qualitative research and on a peer-delivered model. The intervention includes a component that aims at developing skills that ensure that, if they are initiated, new injectors receive high quality of harm reduction information. This version’s features are integrated. The involvement of peers, developed as part of a local service, is central. It was evaluated by a qualitative method.

Results of the Working Group

The militant rhetoric was particularly strong during the first part of the meeting. Conflicts, power at stake and legitimacy issues between actors were obvious and clearly expressed. However, from the second part of the meeting, partners calmed down progressively along with awareness of the importance of union among themselves to act in favor of their public’s health.

They started to reconstruct a common ground and objectives have been clarified, discussed and redefined collectively. During this day, French actors expressed their opinion on hypothetical brakes, levers and conditions for the implementation of a strategy of actions based on the entry into the injection and for the possible adaptation of *Break the Cycle* to the French context.

Conditions in developing a strategy based on the entry into the injection

The need to better understand the topic has been identified by the survey and is corroborated by the results of the working group. Partners want to acquire more data on the percentage of people who inject a first time and don't continue, in comparison with the percentage of people who adopt the practice. The profile of people likely to be initiated to injection, even if such thing is difficult to predict, as well as data on characteristics of people who may accept to initiate and those who may refuse, are seen as essential. More marginally, the bias "entry into the injection" may risk to attract only a part of the audience (those who consider themselves as injectors), while others are exposed to switch to intravenous (or have already practiced) but did not consider themselves as such.

Concerns about the potential stigmatization of the injection practice

Several questions have emerged about the risks of stigma and the risk of greater isolation of the injector, potentially generated by an intervention focused on this practice by trying to avoid it. Self-support groups stated the risk of stigma by separating the injection of other practices while adding that stigma already exists by the HCV outbreaks. According to them, the risk of stigmatization is by conveying the idea that *"initiators are those who may put the "poor non-injectors" in a serious situation*". They think that, in *Break the Cycle* program *"we try to tell someone not to be an injector."*

Promote the exchange on practice of injection into local structures

According to several participants, before attempting to prevent transition to injection or acting for an initiation at lower risk, exchange around the practice of injection should be encouraged and facilitated within proximity structures. It is an essential step before working on the entry into the injection. Many believe that the practice of injection is not easily evoking while *"silence can generate higher risk".* However, they believe that the bias to address this issue is to evoke first the pleasure in drugs consumption and the reasons of this consumption. These issues must be discussed with users, prior to the choice of practice and the associated risks. The framework for evoking the issue of injection is more or less suitable and easy, especially with the young.

Advise, propose and support the transition to other modes of administration

This method seems to be supported by most participants on the condition that users can evaluate the benefit of other modes of administration to transmit it to others. According to actors, it can facilitate the exchange on the practice of injection. Moreover, the proposed alternatives should be decided jointly with users, should be the result of a consultation and should respect the pleasure sought originally by the user. However, to assist users in transition to other modes of administration, knowledge on gesture related to other practices and on drugs that can be consumed by different route must be improved. This approach must take into account the specificities of French culture in terms of taste for certain practices.

Train workers

Always with a view to promote and facilitate the exchange around the practice of injection, the majority thinks that the training of professionals from CSAPA and CAARUD, a priori not able enough to talk about drugs and injection, must be improved. Basic training on drugs and practices less risky seems to miss even though these professionals are often graduated in social work or nursing. The idea to include such training in the general education programs has been proposed which might facilitate its assimilation on the field.

Develop a peer outreach and redefine the term "prevention"

On the one hand, in the context of the entry into the injection, a peer-based approach is adopted by participants even though several brakes to the French context were outlined in its use. On the other hand, improving the relationship and articulation between users and professionals is a necessity as well as collaboration with self-support groups. Furthermore, the restraints on the axis "prevention" among actors require finding a substitute or a common definition of that term. However, the interest of this axis is recognized because it will consider a strategy of action for non-injectors also, that would complement the current French offer of HR, more developed towards the injectors.

<u>Exchanges around the program *Break the Cycle*</u>

Many believe that this program is an attractive option while recognizing that some injectors need help in order to respect their wishes to refuse to initiate other to injection. Many agree that it may allow fostering the exchange around the practice of injection, important need stated by the partners. However, the risk of *"manipulation of right-minded to understand users that it is wrong to inject and that it is important not to initiate"* was noted. The structured dialogue between workers and users in which *“the objective is not defined through consultation*” is another point to the detriment of the commitment of partners in the program.

In addition, many think that priority now is to facilitate the exchange around the practice of injection and train workers. The reflection around this program is may be a bit premature in the light of these unmet needs and because *"workers do not know yet what injection is exactly and what the new uses are. So how can they tell users how not to "fall" into the role of initiator*?"

In the perspective of adapting this program, it would be more interesting if it is based on empowerment* of users for transition and use of other modes of administration, education to injection and initiation. In addition, changing the title *Break the Cycle* into *"Change the Cycle",* like the Toronto version, seems to be an important condition for the French actors and more appropriate to HR principles. Moreover, the objective preferred by participants is to develop the accountability of injectors towards non-injectors and give them means to transmit and make aware them to risks. The association between representative organizations of users and users in the process of adaptation is another important requirement. A joint intervention with the French programs aiming at educating to injection (*ERLI and AAI*) is another important modality. Finally, it must be developed by local services, must target people at high risk and must use a face-to-face method.

PART 4 / PROPOSALS

A. Discussion

On the one hand, this part relies on the analysis of the linking between specificities of the French context (in terms of partnership in the French harm reduction approach, positions of the mains actors for harm reduction interventions targeting the entry into injection, profile of the French drug users etc.) and the strategy of working specifically on the entry into injection to reduce the transmission rate of HCV among IDU. On the other hand, it relies on the analysis of the linking between French context and the *Break the Cycle* program specificities.

Feasibility analysis of implementing a strategy targeting the entry into the injection in France

An intervention strategy in the context of entry into the injection focuses on two main areas: prevention actions of transition to injection intended for a public who want to inject but inclined to change their minds, and interventions in favor of an initiation to injecting as secure as possible for an audience determined to inject. Overall, the lack of data in literature on the process of entry into the injection can potentially hinder the implementation of this strategy, although the experiment might help to acquire it.

A lack of basic training in HR for local stakeholders, brake or lever?

The survey results highlight a major need for training among HR workers and indicate that the current supply must first be consolidated with that aspect. Basic notions about the effects and risks relating to various drugs, knowledge about gestures for various practices and risks associated seem to be missing in local network of stakeholders. The central point is apparently to improve on how to discuss these issues with the public. Thus, before embarking on the development of a new strategy that will probably require updating training of local actors, representatives of HR organizations wish first proceed with the building skills needed to consolidate actions already undertaken in France.

Little initiative on the two axes of the strategy in France, brake or lever?

From the results of investigations with French HR organizations, the subject of entry into the injection seems not to be thought, neither in terms of prevention, nor in terms of initiation to injection. Apparently, no formal initiative has been taken in this direction for now in France. The possible development of this strategy would be innovative but would require a number of conditions. Indeed, this line of work has not yet been tested and touches an intimate subject, little known and which involves a rather young audience. In particular, training of workers is a prerequisite, especially if they have never experienced such an approach. Thus, it involves learning and adopting new practices, new tools and new skills among HR workers. Similarly, the use of a toolbox as wide as possible to tailor the intervention according to the variety of profiles and needs of users and a fortiori, to respect differences, implies probably the acquisition of new skills, broader and more versatile among HR workers. It presupposes also to complete their training in order to be able to assist users according to various strategies.

Actors rather in favor of an intervention on the initiation to injection, brake or lever?

Within the network of French HR actors, the idea of intervening to try to prevent transition to injection is discussed while the idea of intervening in favor of an initiation at lower risk seems more easily accepted. This withholding on the axis "prevention" appears to be related to HR's history, its underlying principles and issues of power and lack of recognition today in France of this approach. Interventions in favor of initiation at lower risk seem more in line with the HR principles according to actors. Indeed, for them, beginning the intervention at the phase of initiation to injection in the trajectory of the individual, suggests that the hypothetical "injection envy" of the person and its enactment are respected.

Moreover, the initiation phase is seen as a strategic moment to pass messages and learn gestures to lower risks. Insiders are rather young, potentially at the beginning of their injector path. Thus, according to HR actors, intervening as early as possible and at the earliest possible age, gives more chance to avoid the inclusion of bad habits which might be harder to remove at a later age. Early intervention can also prevent a high frequency of injection equipment sharing and potentially contamination with HCV.

The favorite intervention in the context of initiation requires an easy access to sterile equipment, learning gestures at lower risks and how to avoid risks. This axe of intervention is quite similar to that developed and promoted in France. Indeed, French actors are experienced in the area of education to injection and to the risks associated. The experience of France in this area can potentially be useful to develop quality interventions in terms of initiation to injection.

Easy access to sterile equipment for injection in France, brake or lever?

The distribution of sterile equipment is central in French HR offer to reduce transmission of infectious diseases. Overall, this offer is accessible and well stocked. It is a major tool to support an intervention in the context of initiation to injection at lower risk. Through this, the implementation of interventions in this context will probably be facilitated in France.

However, according to the survey *Coquelicot* conducted by INVS, a significant percentage of users do not seem to know the risk of contamination present in the sharing of small equipment for preparing the injection. Even if this wide distribution is a major asset to work in the context of the initiation, material use should be a priori, better supported and explained to users. This improvement could be achieved through an intervention on HCV risk perception, through programs like *ERLI* and *AAI* experimented in France, and through existing training materials such as the "artificial arm" or the video *17'10*. The distribution of material seems to be a factor facilitating the implementation of a strategy targeting the entry into the injection but users' knowledge about the infectious risk associated with sharing the small material injection should be improved.

The debate around the method of informing, proposing and supporting the transition to other modes of administration, brake or lever?

French actors are favorable to this method although several issues relating to compliance with principles of HR are grafted to the debates. Even though French actors express restraints for the prevention process of transition to injection, it seems to be more acceptable to them, to act in prevention of transition to injection by offering another mode administration to users, rather than preventing the transition to injection without proposing any other alternative and potentially leave the individual in a possible frustration.

Indeed, according to French actors, envy, expectations and user's choice should be respected. The exchange in order to try to find with him the method of administration which will make the effects the most similar to those originally sought is also central.

Actors think that other modes of administration than injection can be offered to users prior to entering the injection and during their injector's path for making a break or exiting permanently the injection practice. Consistent with principles defended by self-support groups, this method remains neutral towards user's choice to use drugs. Indeed, it does not seek to accompany the patient towards the exit of the drug, as he does not express this wish. However, principles of HR push actors to emphasize the use of this method with injectors who need a break in their practice (vein problems, abscesses etc.). Thus, the intervention of professional would be based on an expressed demand and a felt need by users.

Moreover, according to them, this method has the advantage of being adaptable to different audiences and can be used in all phases of the user's trajectory. It is entirely consistent with the use of a wide toolbox. The diversity of tools and approaches proposed in this toolbox shows some respect towards the choice of the individual and can allow an appropriate response to his lifestyle, without showing a position varying between the "good" or the "wrong" direction.

However, according to self-support groups, this method seeks to potentially "remove" the injection practices or at least to suggest it. This method is therefore likely to condemn the practice of injection by putting it aside. Interventions to prevent transition to injection may induce potentially the same objective. Yet most agree that this practice is at high risk of infection and that the principles of the HR legitimate the need for action on these risks. Thus, if one accepts that risk of contamination with HCV is higher in injection and that HCV is a major damage of this practice, then we may act first on risk (injection practices) and try to make it disappear completely (preventive approach). Or should we continue to recognize and admit the use of injection and act instead on situations most at risk, within this practice (HR approach)? French actors do not seem to support interventions to eradicate injection practice, even though they consider it as a high infectious risk. They seem more in favor of limiting risk-taking within the practice to reduce contamination by HCV.

The example of Break the Cycle program: feasibility analysis of its adaptation to France

The benefit of this program is that it is almost alone in the world to offer an intervention in the context of entry into the injection. The results of the collective expertise of INSERM showed that *Break the Cycle* is a promising program in relation to reducing the transmission of HCV among DU. Its main weakness is the lack of evaluation of its intervention according to its initial structure since 1998.

However, since, *Break the Cycle* has been adopted in a dozen countries and several local forms have been evaluated (U.S., Toronto etc.), although few papers have been published on the subject. Obtaining sustainable financing for the implementation of a new intervention in France depends heavily on the existence of evidences through scientific studies and assessment. In addition, several international experiences show that sustainable financing contributes greatly to the success of its local operations. However, experimentation of this program may help to obtain such data, if a collect is planned during the pilot phase.

A program focusing on the practice of injection, brake or lever?

The results of the international survey show that this program promotes and encourages the exchange around the injection, around initiation to injection and around damages associated to the practice such as vein problems, hepatitis C, overdose etc. In France, according to actors, exchange around the practice of injection between users and professionals should be reinforced within a community setting. The lack of training among workers is one of the main brakes while these exchanges are considered as the first step in implementing a strategy in the context of entry into the injection. Thus, on the one hand, *Break the Cycle* could potentially help to make this step, in facilitating discussion around this subject.

On the other hand, the risk of stigma of the injection practices and a fortiori, risk of isolation of injectors has been evoked by self-support groups mainly, potentially generated by an intervention focusing on this practice. Self-support groups are rather opposed to the idea of separating the injection to other practices. They tend to disagree with a speech in interventions that show and support the idea that injection is negative and "must be avoided" because it's contrary to HR principles.

The discussion between French actors around the peer approach, brake or lever?

French actors agree on the use of a peer-based approach for intervening in the context of entry into the injection. Indeed, they believe that peers are more likely to be present at the first injection than professionals. In any case, one of the highlights of this program is the principle of close cooperation with peers who are dedicated to intervene towards non-injectors. For this main reason, it is perceived as interesting. Yet many agree that communitarian health is difficult to develop in France and numerous serious obstacles remain. Several modified versions of the program based on a peer approach, has shown positive results (Toronto, U.S. etc.). In the U.S., the investment of peers was compensated, a modality which is not possible in France.

Apart from the peers, in the same objective, a close partnership with teams of the party scene and strengthening street teams are important conditions. However, no experience coping *Break the Cycle* still evoke this modality, but this track is probably an option to study for the French context.

Actors for close cooperation between users and professionals, or brake lever?

According to French HR actors, close cooperation and consultation between professionals and users or self-support groups are conditions for the smooth implementation of a new strategy but also for the adaptation of a new program. The results of the international survey on the international experiences of *Break the Cycle* support this idea. Indeed, some versions have resulted in failure because of the lack of consultation with these stakeholders.

The debate about the beneficiaries of the intervention, brake or lever?

Although some French actors seem to attach importance to the scope of the beneficiaries for such intervention, most agree on the principle of targeting an audience at risk, ie those attending festive events and those living in squats. Regarding this point, several international successful experiences of adaptation of *Break the Cycle* chose to target a specific audience (Toronto: young street, Vietnam: sex workers etc.) and / or a specific problem or need (HIV, overdose, HCV) also.

But to ensure a lasting commitment of peers and ensure the use of a community approach in the long term, the main need addressed must be felt and perceived as a risk among the public. It must be identified and defined in consultation with them. In France, reduction of HCV transmission among IDU is a Public Health priority for actors and Ministry of Health but it is not necessarily a major concern among IDU to date.

In addition, *Break the Cycle* relies on the assumption that initiation is usually performed by a peer. Originally, the intervention targets peers injectors who may initiate others, to prevent the transition to injection. The targeted audience of injectors is visible and accessible via the proximity structures. Thus, initially, neither non-injectors, nor users in precarious situation or inserted users, very distant from structures, are direct targets of the program. The initial version of the program does not appear to target an audience whose age corresponds to the average age of entry into the injection neither. However, exchanges on the forums of French self-support groups show that the injection is gradually gaining ground among public more inserted who tend to learn alone (this figure must however be confirmed by the results of the exploratory investigation of INPES). It should be noted that several international experiences of successful *Break the Cycle*, chose to target other types of audiences that those from structures, such as Toronto where interventions are conducted with street youth.

The results of evaluation of the adapted version in U.S. highlight the need to tailor the intervention based on differences in the position of peers. The more experienced ones convinced of their choice to initiate to injection or not and the younger, who have not yet studied the pros and cons in such decision don't have the same needs. These various positions among peers were highlighted by French actors. These elements must be taken into account in the definition of *Break the Cycle* in France.

French actors rather in favor of an intervention on the initiation to injection, brake or lever?

Many believe that the emergency in France is to intervene at the time of initiation to injection, in preventing the use of unclean material and the need to give maximum information to users during its first injection. This trend is consistent with the strategy tested in France today (education for the injection and the associated risks, *ERLI* or *AAI* programs). According to French actors, the peer approach is particularly suited for an initiation to lower risk. Thus, empowering injectors to teach new movements and safer practices is an important goal. However, according to the actors, in the need to intervene at all phases of user's trajectory, interventions focusing on "initiation at lower risk" must be attached to "preventive actions".

Originally, *Break the Cycle* has been designed with the aim of preventing transition to injection. However, initiation phase has been developed jointly to the prevention component in several countries (Toronto and the U.S.).

A flexible program to more integrated specificities, brake or lever?

Although initially *Break the Cycle* is designed more to prevent transition to injection, some countries have at the same time, an intervention based on the education to safer injecting for regular injectors, actions in favor of an initiation at lower risk and responses to peer injectors to prevent transition to injection. These versions seem consistent with French actors' expectations, who think that the program in France should not be turned towards one goal in order to remain neutral towards user's choice of lifestyle. The analysis of these integrated versions provides additional elements to adapt the program to the French context. The city of Marseille is particularly interested in developing an integrated version of *Break the Cycle*. Negotiations are underway to obtain funding. Modalities to form the workers are being discussed. This initiative is an important lever to consider in the experimentation of *Break the Cycle* in France.

The debate surrounding the role of the injectors towards non-injectors, brake or lever?

For prevention of transition to injection, the favorite action is to inform peers on the potential impact of their attitudes on non-injectors (inject or talk about the injection positive in front of them may increase the risk of transition to injection).

Consistent with HR principles, this message should not be passed as an injunction (do not inject in front of others, do not talk about injecting positively). It should be transmitted in the objective of informing and raising awareness among injectors on these risks. In addition, according to French actors, action towards injectors should aim at empowering them and helping them to undertake a protective role towards non-injectors. The model of this program is involved in this logic of awareness, information and awareness of injectors. However, the idea of helping injectors to apprehend a protective role towards others was never raised in these terms by the program manager. The analysis of the international experiences, does not show this logic of intervention neither. The potential value added, apparently stated by French actors, must be explored.

For an adjustment of the program to the specificities of the local culture of drugs consumption, brake or lever?

According to France, another major condition for carrying out the possible adaptation of a foreign program is taking into account local specificities in terms of drug culture (type of product, taste for certain practices, language used in the tools and materials etc.). Besides, several experiments at have failed due to the use of inappropriate tools. Most of these experiments were imported and used the tools as they were built in the original version of *Break the Cycle*.

A. Conclusion, recommendations

This document provides an overview of the French HR supply, to feed the feasibility study of implementing a new strategy of interventions to reduce transmission of HCV among IDU in France. This new strategy could be developed in France through the adaptation of the English program *Break the Cycle* but under the respect of several important conditions.

Firstly, the results of investigations highlighted the need for coordination and articulation between French HR actors around the subject, corroborated by the analysis of international experiences of *Break the Cycle* showing that close collaboration with self-support groups is a major condition for a sustainable adaptation. Thus, the need to improve coordination and obtaining a first consensus on modalities for implementing this strategy has therefore led INPES to begin coordinating partnership thinking around it. Coordination of actors was a key stage of the study, but difficult to overcome with regard to issues of power and many barriers (political, semantic, historical, etc.).

The speech sometimes "activist" has lost sight from time to time, of several aspects of the overall well-being of the individual. However, consultation with the main stakeholders was established early in the process but might be consolidated in the coming months.

Furthermore, *Break the Cycle* has been identified as a promising program for the reduction of HCV among IDU by scientists of the collective expertise of INSERM. However, since the publication of the results of this expertise, no other scientific approach has been employed to study the "potential" of this program in reducing HCV among IDU. This lack of connection with scientific organizations has constituted a major limitation of the study. However, it should be noted that the assessment of the impact or the efficiency of this intervention is only possible through its experimentation. And this experimentation relies largely on the agreement of associations, local services and self-support groups.
However, more links with scientific organizations earlier, would have feed the debates and provide objective data that might have defused the "passionate" debates. Thus, *Break the Cycle* program should be supported ultimately by a scientific assessment. Its effectiveness should be proven through rigorous statistical studies of type randomized controlled trial from its "pilot" phase in relation to the reduction of HCV among IDU.

Another major limitation is the confusion generated by the coordination of this project by an agency under the Ministry of Health. Indeed, its position towards HR is not quite in agreement with the position of associations. The risk of assimilation of the State's position with that of its agencies (here INPES) by associations was taken into account. Questions about the legitimacy of INPES in the coordination of this process towards civil society actors on one side and towards its guardianship of the other side have been raised. The role of INPES in this project is another element to specify in the coming months.

The absence of formalized process and document for carrying out a feasibility study has been another important limitation. Indeed, this study required the design of a methodological framework and appropriate analytical tools. In order to follow a rigorous scientific approach in its implementation, a background paper on the approach and methodology of such studies would have been useful.
More precisely, from a strategic point of view, in order to integrate this new strategy into the French HR supply successfully, a respect of the main principles defended by French actors and especially by self-support groups is required. Thus, interventions may not seek to challenge the choice made by the person (using drugs, using a particular practice or consuming a particular product).

The new HR strategy should be able to offer various forms of responses to users, while respecting differences and adapt to the diversity of profiles. Thus, all interventions within the context of entry into injection should be integrated into a wide range of tools in order not to show a single purpose of "avoiding injection". The establishment of a toolbox including tools and approaches for different purposes (initiation to injection at low risk, prevent, educate, etc.) is expected. Consistently, the hypothetical French adaptation of *Break the Cycle* would be integrated into a wide range of approaches and tools as well. Thus, the aspect of preventing transition to injection should be developed jointly with the axis "initiation to injection at lower risk". An integrated version of *Break the Cycle*, like Toronto's version, is preferred in France. The French version of this program should be associated with French interventions experimented in France (*ERLI, AAI*). The initiative of Marseille on a possible future launch of the program in an integrated form is an important thing on which to build. In this context, integration of the manager of this initiative at future meetings will become necessary. A new name for the program more consistent with integrated features should be decided collectively. In the context of initiation at lower risk, use of sterile equipment by users should be strengthened.

The method of transition to other modes of administration is another area to develop. However, this method should be used on the basis of close consultations with users, putting in perspective with the searched effect and that produced by a given practice. Users' expectations, their social and health status, their history and the benefit of a new mode of administration should be discussed. The development of this method should also be based on a consideration of local specific character in terms of types of drugs in circulation which facilitate more or less transition to other practices. The basic method "chasing the dragon" used in *Break the Cycle* should be developed jointly with French initiatives taken in this regard (Distribution of aluminum foil in squats and festivals etc.).

In the French version, messages transmitted under an injunction form should be avoided. Raising awareness among injectors about the risks in order to push them to protect others might be preferred. It should be implemented by local services and target people at high risk (young). The expansion of the action to a remote public from structures (through peers, party scene and street work) is other important points to have in mind.

However, before French actors' commitment in a possible implementation of such a strategy, a better understanding of the process of the entry into the injection is required. These data could be obtained if data collection is foreseen in the *Break the Cycle* pilot phase. This should be articulated with the analysis of the exploratory survey Priminject coordinated by INPES.

Before going further in the possible implementation of this strategy, the need of reinforcement of HR workers' training in HR's basic notions should be covered. In addition, this strategy will probably require new skills, practices and knowledge for them. The use of a toolbox and the use of the method of transition to other modes of administration will probably require skills more versatile as well among professionals. One of the main negative consequences of this lack of training is insufficient discussions around the practice of injection in proximity structures. The French version of *Break the Cycle* must maximize the advantage of being focused on the practice of injection and thus promote the exchange around the injection within its interventions.

Overall, it must be recalled that the goal of public health actions is improving the health of individuals through physical health, psychological well being, his integration in society (family, friends etc.) and the ability to meet his own needs and having access to appropriate care. But, in the context of being an injector, is it possible to get all these factors? Are there examples of users using the practice of injecting regularly and in a long term, who benefit from all these benefits?

Furthermore, posting a position on the practice of injection and acting within its existence may contribute to the marginalization of individuals and thus may provide a partial health service to IDU. Is the practice of injection, a factor of marginalization? If so, principles of HR may keep them in this marginality. In this case, a problem of unequal access to health care may arise.

Conversely, a position suggesting a necessary limitation of this practice may make public more difficult to access and therefore also would contribute to his marginalization. Indeed, this public is rather volatile, in the grip of an exclusive relationship with drug (and / or practice) which cannot be detached physically or psychologically. To get in touch with them, condition is may be to accept this exclusive relationship and work on it afterwards, as soon as the user feels in confidence enough with workers. Pleasure sought in injection is sometimes compared to sexual pleasure. The comparison between condom use and sterile equipment use in the aim of continuing to get fun while protecting themselves are sometimes mentioned.

Finally, despite this context little easy, it should be noted that all French HR stakeholders recognizes the importance of unity, consultation and coordination between them to combat the epidemic of HCV among IDU. After four months, results are positive and encouraging in terms of partnership. Actors are in favor of a co-construction process of a new strategy to combat this epidemic. And a strong partnership is the major condition for a sustainable adaptation of *Break the Cycle*.

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GLOSSARY

C-D

Central nervous system depressants: this type of substances reduces the overall activity of the brain and has a relaxing effect

Chasing the dragon: use of heroin by inhaling the vapors, which occur when the drug is usually heated on aluminum foil over a flame

Crack or « free base » or « cocaine base »: stimulating substance obtained by adding bicarbonate or ammonia to cocaine hydrochloride. The product is also called "free base" or "cocaine base" by users. It is generally smoked but can also be inhaled and injected less frequently (after dissolving in water containing an acid medium). The crack is in the form of cakes (called "rocks" or "pebbles"). The product causes a sensation of lightning flash more powerful than that induced by cocaine (OFDT)

Desensitization: to make emotionally insensitive, less sensitive or unresponsive, as by long exposure or repeated shocks

Disruptors of the central nervous system: this type of substances called also “hallucinogens” causing alterations in perception and mood

E-H

Empowerment: process or approach that aims to enable individuals, communities, organizations to get more power of decision and action and more influence over their environment and their lives. This approach is applied in many areas (social, health, economy etc.) and is designed very often for victims of social inequality, economic, gender, racial etc. (*Culture & Santé*)

Experimental or occasional use: unique consumption. The product's use is rather in friendly circumstances. The quest for pleasure, calm or desinhibition may be the reasons for this use

Front-line structure: specific proximity structures for the UD called "at low threshold of requirement" that is to say they apply low criteria for admission. These structures provide benefits to addicts who do not or cannot entry into a conventional treatment. They also provide activities related to health promotion and harm reduction (eg needle exchange programs etc.)

Harm Reduction: public health approach to address issues related to drugs and focusing primarily on reducing the negative consequences of drug use on health, social and economic rather than eliminating drug use

I-O

Ingesting (mode of administration): for substances in tablet form. This is to swallow the tablet

Inhaling (mode of administration): the drawing of air or other substances into the lungs

Injecting by subcutaneous (mode of administration): Under the skin. "Subcutaneous" implies just under the skin. With a subcutaneous injection, a needle is inserted just under the skin

Injecting by intramuscular (mode of administration): an injection given directly into the central area of a specific muscle. In this way, the blood vessels supplying that muscle distribute the injected drug via the cardiovascular system

Integrated approach: refers to agencies in a catchment working in a collaborative manner using a mix of health promotion interventions and capacity building strategies to address priority health and wellbeing issues

Lawful: allowed by law but most regulated

Modes of administration: the methods of route or modes of administration are defined as "the way in which a substance is introduced into the body" (WHO)

Opiates: any substance containing opium or performing an action similar to that of opium

P-R

Party scene: locations of festive events under the techno culture. The event takes place in a closed club or a private party or outside at a *free party* or at *technival* where people usually dance, drink and consume psychotropic (OFDT)

Peer-based approach: based on the premise that peers may play a specific role in prevention of the difficulties of vulnerable populations or they may promote change in attitudes and values (McDonald et al, 2003; Shiner, 1999; Turner and Shepherd, 1999, Ward 1997)

Poly drug use: means the act of using at the same time or consecutively several products on a single occasion. This practice describes both the overlapping of regular consumption of main psychoactive substances, but also the overlapping of uses during the life or the year other illicit psychoactive substances

Prevention: an anticipatory measure to prevent that an undesirable state of affairs occurs (Low, K.)

Psychoactive substances: substances that can cause changes in perception, mood, consciousness, behavior and modify various physical and psychological functions

Recreational use: use of a substance only when this use is socially acceptable and when the substance is readily available. The person does not seek and do not create situations conducive to the consumption

Regular of harmful use (abuse): means the act of consuming a substance at least 10 times over the last 30 days. Use with a risk of psychological dependence and loss of user-friendliness, repeated use may induce damage somatic, psycho, economic, judicial and social for the subject and his environment

S-U

Stimulators of the central nervous system: this type of drugs increase the activity of the brain and mental processing speed

Self-support group: association of representatives of drugs users

Snorting: snuff, sniff

Steribox: prevention kit for drug users with a set of tools for sterile injection distribute free or at low cost : 2 alcohol swabs, 2 syringes, 2 vials of sterile water, a condom, 2 cups, 2 filters, 2 dry pad

Substitute treatment for opiates: replacement therapy involves administering a substance with effects similar to the substance of which the subject is addicted, but has a more advantageous pharmacological profile. These are prescribed by the doctor and have the goal of treating addiction in a medical and legal framework

Taste the flash: the pleasurable sensation that accompanies the use of a drug (a "*rush"*)

Unlawful: drugs for which the penal code prohibits and penalizes the production, possession and sale and whose use is prohibited and punishable

LIST OF ANNEXES

ANNEXE I

Décrets, arrêtés, circulaires

TEXTES GÉNÉRAUX

MINISTÈRE DES SOLIDARITÉS, DE LA SANTÉ ET DE LA FAMILLE

Décret n° 2005-347 du 14 avril 2005 approuvant le référentiel national des actions de réduction des risques en direction des usagers de drogue et complétant le code de la santé publique

NOR : *SANP0521129D*

Le Premier ministre,

Sur le rapport du ministre des solidarités, de la santé et de la famille,

Vu l'article L. 3121-5 du code de la santé publique,

Décrète :

Art. 1er. – En application de l'article L. 3121-5 du code de la santé publique, est approuvé le référentiel national de réduction des risques en direction des usagers de drogue annexé au présent décret.

Art. 2. – Le chapitre Ier du titre II du livre Ier de la troisième partie du code de la santé publique (partie réglementaire) est complété par une section 6 ainsi rédigée :

« Section 6

« Politique de réduction des risques pour usagers de drogue

« *Art. D. 3121-33.* – Le référentiel national de réduction des risques en direction des usagers de drogue mentionné à l'article L. 3121-5 est reproduit à l'annexe 31-2 du présent code. »

Art. 3. – Il est inséré au code de la santé publique une annexe intitulée :

« ANNEXE 31-2

« RÉFÉRENTIEL NATIONAL DE RÉDUCTION DES RISQUES
POUR USAGERS DE DROGUE MENTIONNÉ À L'ARTICLE D. 3121-33 »

et reproduisant les dispositions annexées au présent décret.

Préambule

L'article L. 3125-1 du code de la santé publique issu de la loi du 9 août 2004 relative à la politique de santé publique prévoit la définition d'un cadre de référence pour les activités de réduction des risques en direction des consommateurs de stupéfiants. Les acteurs, professionnels de santé ou du travail social ou membres d'associations, comme les personnes auxquelles s'adressent ces activités doivent être protégés des incriminations d'usage ou d'incitation à l'usage au cours de ces interventions. Les services en charge de la répression du trafic et de l'usage de stupéfiants doivent pouvoir clairement reconnaître les acteurs et les activités relevant de la réduction des risques. Les associations menant des actions de réduction des risques doivent se faire connaître du chef de projet dans le département de leur siège social. Enfin, les habitants des quartiers et les élus qui les représentent doivent être associés à ces activités en étant informés des principes qui les guident, de leurs modalités et de leurs résultats, afin de favoriser leur implantation et d'intégrer la réduction des nuisances et des tensions à leurs objectifs. La réduction des dommages repose à la fois sur des interventions qui visent directement les consommateurs et sur une mobilisation des services ou des associations qui peuvent favoriser leur inclusion dans la collectivité par la concertation et la médiation au bénéfice des usagers et de l'ensemble des habitants des zones de résidence concernées.

Non aux salles de shoot en France

Philippe Goujon

Aux yeux de leurs opposants, les salles de consommation de drogues apparaissent comme une entreprise visant à encourager la consommation de stupéfiants, à affaiblir l'efficacité de la politique française de réduction des risques et sont un foyer potentiel de désordre à l'échelle des quartiers où elles sont implantées.

Les Français ont du bon sens : 85 % sont opposés à la dépénalisation de la drogue et 73 % rejettent l'ouverture des salles d'injection de drogue[1]. Les partisans de ces « salles de shoot » s'appuient néanmoins sur une récente étude de l'Inserm (Institut national de la santé et de la recherche médicale) pour appeler à leur création en France. Pourtant, sortir les jeunes de la drogue, ce n'est pas leur en faciliter l'accès, mais les inciter à ne pas en consommer et accompagner ceux qui s'y adonnent à s'en libérer.

Contre le fatalisme ambiant, pour amener les toxico-dépendants à quitter le chemin de souffrance et de désespérance qui les conduit à la misère, à la détresse et à la maladie, nous avons à cœur de démontrer aux plus fragiles que les pouvoirs publics sont décidés à les protéger s'il le faut contre eux-mêmes ou plutôt contre l'instrumentalisation dont ils font l'objet.

Rien, en effet, ne serait pire que, pour un bénéfice très discutable en terme de santé publique – l'étude de l'Inserm affirme que les salles d'injection semblent sans effet sur l'incidence du VIH et du VHC (Virus de l'hépatite C) –, on prenne le risque de semer la confusion dans l'opinion publique en donnant l'impression que l'État accompagne, voire facilite la consommation de drogue, alors même que celui-ci, dirigé par la gauche ou par la droite, en a toujours formellement proscrit l'usage.

Un affaiblissement de la politique de réduction des risques

Une autre conséquence néfaste serait de troubler le message, comme de décourager tous ceux, éducateurs, médecins, travailleurs sociaux, dont l'engagement et le métier sont de soigner et de prévenir l'usage de drogues, d'aider à la réinsertion, sans même évoquer les familles – dont le rôle est si important – désemparées par une telle incohérence. Il en résulterait inévitablement un affaiblissement de la politique de réduction des risques aux yeux d'une partie de la population. Ce serait d'autant plus dommage que, contrairement aux seuls huit pays où sont autorisées les salles d'injection, notre pays a enregistré des résultats probants en terme de baisse des contaminations par le VIH (divisés par quatre en quinze ans) ou d'overdoses mortelles, divisées par cinq avec le taux le plus bas d'Europe.

Car il existe d'autres moyens d'atteindre les objectifs que se fixent ceux qui préconisent des salles d'injection sans pour autant permettre aux usagers les plus vulnérables d'absorber leur dose quotidienne, avant d'ailleurs sans doute de leur fournir gratuitement. Sait-on qu'en France existent pas moins de 200 structures de soins dédiées aux usagers de drogue : Centres d'accueil et d'accompagnement à la réduction des risques (CARRUD), dont un dédié aux usagers de crack à

1 Enquête sur les représentations, opinions et perceptions sur les psychotropes (EROPP) menée fin 2008 auprès de 2300 personnes âgées de 15 à 75 ans sélectionnées aléatoirement et interrogées par téléphone.

ANNEXE III

QUESTIONNAIRE FRAME FOR INTERNATIONAL TEAMS OF BREAK THE CYCLE

1. Can you give us a brief history of Break the Cycle in the country? *(origin of your idea, what led you to adapt this program, the elements that made you motivated, confident and convinced…)*

2. Can you describe briefly the context on which the (adapted) program operates in the country? *(geographical, environmental, economical (poverty, inequalities..), socio-economic situation, political, existing health programs…)*

   2 a) Do you consider the effective targeted area as relevant today? Why?

3. Can you describe briefly the public with which the (adapted) program operates? *(epidemiological situation, public's profile: social problems, medical problems, lifestyle, health issues etc. …)*

   3 a) Do you consider the effective targeted public as relevant today? Why?

4. Can you describe briefly the various stages of adaptation/implementation of Break the Cycle in the country? *(conception, planing, programing etc…)*

5. What were the main difficulties in adapting/implement Break The Cycle in the country?

6. How have you addressed these problems? *(how have they been supported)*

   6 a) What problems have been resolved?

   6 b) Once these problems solved, are the results satisfactory?

7. a) Initially, what were the external opportunities which led you to implement this program?

   7. b) What were the external threats of this program?

8. What are the methods of intervention of Break the Cycle (adapted) in the country ? *(collectively, individualy, by interviews, what kind of supports, educational tools, information, empowerment sessions…)*

   8. a) How did you define your methods of intervention? *(In other words, for example collectively? or the program manager alone?, with all partners?, in a working group? etc. ..)*

   8. b) What are the methods of intervention most effective today? Why?

9. What are the partners of the program?

9. a) Could you comment briefly on the main weaknesses and main strengths of the partnership on the program?

9. b) Could you comment briefly on the evolution of the partnership on this program?

10. Can you describe briefly your method of evaluation?

10. a) How did you define your method of evaluation? *(*In other words, for example collectively? or the program manager alone?, with all partners?, in a working group? etc. ..)

10. b) Could you comment briefly on the main weaknesses and main strengths of the method of intervention?

10. c) Could you give us some results of the evaluation of your program (qualitative and quantitative if possible)?

11. What is the funding of the (adapted) program?

12. What are the means employed? *(human and material means, number of persons, working time, etc….)*

13. Can you give us a short feedback on the sustainability of the program? *(the main internal strengths of the program, the main internal weaknesses on the whole)*

14. Finally, we are strongly interested in any advices, recommendations you could give us…

_____
_____
_____
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Again, thank you very much for your cooperation!

ANNEXE IV

BREAK THE CYCLE / ANALYSIS OF ITS ADAPTATION PER COUNTRY				
COUNTRY:				
ESTIMATE (before its implementation)		***SURVEY'S AXES (questions)***	**RESULTS (after its implementation)**	
Situation of the TARGETED area		*1. Can you describe the context on which the program operates effectively? (overall findings, social and health status, environment, services, residential area, type of population, etc. ...)*	Situation of the area affected by the program	
TARGETED health and social needs and issues		*2. Can you describe the public with which the program operates effectively? (targeted-public profile: social problems, medical problems, lifestyle, needs and health issues of this specific population, number of people involved etc. ...)*	Social and health needs and issues affected by the program	
TARGET audience			Audience affected by the program	
Objectives		*3. Were you forced to revisit the estimated objectives of your program after its implementation?*	Global objectives of the program (optional)	
		3a. If so, what are they today?		
		3b. What objectives do you consider being met? what goals are not and why?	Objectives achieved (qualitative and quantitative)	
EXPECTED Results		*4. Were you forced to revisit the theoretical expected results of your program after its implementation?*	Expected results (optional)	
		4a. If so, what are the expected results today?		
		4b. What results do you consider being met today? what results are not and why?	Results achieved (qualitative and quantitative)	
Modes of action ENVISAGED		*5. What are the methods of intervention? what tools do you use, what approach?*	Current modes of action	
		6. What are the methods of intervention most effective and why?		
Assessment methods ENVISAGED		*7. How do you assess the impact of your program: what tools and methods?*	Current assessment methods (évaluation et impact)	
		8. How do you assess the performance of your program: what tools and methods?		
		9. Briefly, can you give us some results of the evaluation of your program's impact		
		10. Briefly, can you give us some results of the evaluation of your program's performance		
PROPOSED Program manager		*11. Who is the program manager? Why?*	Program manager	
Management strategy ENVISAGED		*12. What type of management strategy does he/she exercise ? why?*	Adopted management strategy	
Partners CONTACTED		*13. what are the partners of the program?*	active partners	
		Is the partnership around this program efficient? Why?		
Budget/means ESTMATED		*What is the budget of the program? what is the height of the means employed?*	Costs/expenses	
		Is it sufficient?		
External opportunities for Break the Cycle's adaptation?		*What are the internal strengths of the program today?*		
External threats?		*What are the internal weaknesses?*		
Main barriers?		*What are the main barriers today?*		
Main levers?		*What are the main levers?*		
		Other Results (efficacité/résultats/cost-effectiveness, nombre de personnes touchées etc.)		
		Any advices, recommendations		

BREAK THE CYCLE/ CROSS ANALYSIS OF INTERNATIONAL VERSIONS								
AXES	Australia (Queensland)	Central Asian Republics	Australia (New South Wales)	US	Aberdeen, Scotland	Vietnam	Toronto	South East Europe
Situation of the area affected by the program								
Social and health needs and issues affected by the program								
Audience affected by the program								
Global objectives of the program								
Objectives achieved today (qualitative and quantitative)								
Expected results								
Results achieved today (qualitative and quantitative)								
Current modes of action								
Current assessment methods (evaluation et impact)								
Program manager								
Adopted management strategy								
active partners								
Costs/expenses								

ANNEXE V

TRAME DE L'INTERVIEW AUPRES DES ACTEURS NATIONAUX

Objectif de l'enquête : Dresser une typologie des interventions qui ont cours en France autour des Alternatives à l'injection (RDR compris)

Préciser le positionnement (représentations) des acteurs autour de cette approche et leurs attentes

Nom de la personne contactée : Fonction : Structure : Coordonnées :	<u>En cas d'orientation vers un autre interlocuteur</u> Nom de la personne : Fonction : Structure : Coordonnées :

1. **Brève présentation de l'association/organisation/ de la ou des structure (s)**
   - ❖ Date de création ?
   - ❖ Mission/objectifs
   - ❖ Secteur
   - ❖ Equipe

2. **Eléments sur la prévalence de l'infection à VIH/VHC parmi le public**
   - ❖ Existence de données chiffrées VIH/VHC?
   - ❖ Age des personnes infectées ?
   - ❖ Antériorité de la contamination ? tu cherches quoi, des moyennes ? (par clair ; on peut parler de durée de conta en années à partir de l'infection estimée.
   - ❖ Situation sociale des personnes infectées ?

3. **Eléments sur la prévalence de l'injection parmi le public**
   - ❖ Existence de données chiffrées ?
   - ❖ Age moyen des injecteurs ?
   - ❖ Profil social et culturel (ex bulgares) ?
   - ❖ Antériorité de la pratique ?
   - ❖ Situation sociale des injecteurs ?

4. **Ce que vous faites en matière de réduction des risques auprès des injecteurs (quels risques ?)**
   - ❖ Quelles pratiques ? ponctuelles ? durables ? Expérimentales ou standardisées ? basée sur de la théorie
   - ❖ Actions/programmes spécifiques ponctuels, durables ?
   - ❖ Outils/matériel utilisés ?
   - ❖ Fréquence de ces pratiques ?
   - ❖ Qui met en œuvre ces pratiques (dans quel type de structure, quel type de professionnel) ?
   - ❖ obstacles ?
   - ❖ éléments facilitant ?
   - ❖ Résultats ?

5. **Ce que vous faites pour limiter le risque infectieux chez votre public injecteur (à préciser par rapport à la question précédente)**
   - ❖ Quelles pratiques ? ponctuelles ? durables ? Expérimentales ?
   - ❖ Actions/programmes spécifiques ? ponctuels ? durables ?
   - ❖ Outils/matériel utilisés ?
   - ❖ Fréquence de ces pratiques ?
   - ❖ Qui met en œuvre ces pratiques (dans quel type de structure, quel type de professionnel) ?
   - ❖ Freins ?
   - ❖ Leviers ?
   - ❖ Résultats ?

6. **Avez-vous ou travaillez-vous sur les alternatives à l'injection ?** Pour les nouveaux programmes, demander systématiquement ce qu'ils en pensent, leur commentaires, etc….

7. **Ce que vous faites pour limiter le nombre de passage à l'injection chez votre public ou parmi les personnes en contact avec votre public** autrement dit ce que vous faites (ce que prévoit votre programme) quand vous/vos équipes sont confrontées à un jeune injecteur ou en demande d'aide ? (pas clair)

- Quel type de pratiques ? ponctuelles ? durables ? Expérimentales ?
- Actions/programmes spécifiques? ponctuels ? durables ?
- Outils/matériel utilisés ?
- Fréquence de ces pratiques ?
- Qui met en œuvre ces pratiques (dans quel type de structure, quel type de professionnel) ?
- Freins ?
- Leviers ?
- Résultats ?

8. Comment évaluez-vous vos actions/pratiques ? (outils, rythme)

- sur le risque infectieux
- sur le passage à l'injection

ANNEXE VI

CHART ANALYSIS OF DATA COLLECTED IN THE FRENCH STRUCTURES		
Location area of the structure:		
Specificities of the public:		
State of the local partnership:		
PROFESSIONAL PRACTICES IN HARM REDUCTION (within the structure)…		EXPECTATIONS/ POINTS TO IMPROVE
RELATED TO THE STERILE EQUIPEMENT FOR INJECTION DISTRIBUTION		
RELATED TO EDUCATION TO RISKS ASSOCIATED WITH INJECTION		
RELATED TO STREET WORK		
RELATED TO CARE AND PREVENTION FOR HCV		
OTHER HR PRACTICES EXPERIMENTED		
TRAINING		

COMPILATION OF VIEWS ON THE BREAK THE CYCLE PROGRAM	
SURVEYED STRUCTURE:	
RECOMMENDATIONS FOR THE IMPLEMENTATION OF THE PROGRAM IN FRANCE:	
LIST OF BRAKES MENTIONED DURING THE INTERVIEW	**LIST OF LEVERS MENTIONED DURING THE INTERVIEW**

ANNEXE VII

Intervention strategies related to entry into the injection / alternatives to injection
1st meeting: Wednesday, April 27, 2011

Agenda
Room 4A, 4th Floor, INPES

9.30 – 9.45 am Welcome to participants

9.45-10.00 am Introduction ***Anne Guichard (INPES)***

10.00-10.30 am Presentation of *Break the cycle* ***Neil Hunt (KCA, UK)***

10.45-11.00 am Discussion

11.00-11.30 am Put into perspective the French context from interviews with partners, professionals, and French speakers on the topic ***Caroline Cantiteau (practicum EHESP- INPES)***

11.30-11.45 am Discussion

11.45 am-12.30 pm Analysis of international experiences to adapt Break the Cycle ***Neil Hunt (KCA, UK)***

12h30-2.00pm **Lunch (**meal tray)

2.00-4h00 pm Round of the French experiences: Discussion on successive issues and challenges related to a strategy of action surrounding the entry into the injection and alternatives to injection in the French context

4.00- 4.15 pm **Coffee**

4.15-4.45 pm Presentation of preliminary results of the survey PrimInject ***Anne Guichard and Romain Guignard (INPES)***

4.45 pm Last word!

ABSTRACT

The prevalence of Hepatitis C Virus (HCV) among Drugs Users (IDU) in France is between 40 and 50% while for HIV, it is between 6 and 8%. The intravenous route is recognized as the most at risk practice for HCV. Stem this phenomenon is a public health priority for the Department of Health and for other Harm Reduction (HR) French actors. The existing French Harm Reduction have proven its positive impact in reducing HIV, but do not show as effective in stemming the epidemic of HCV. The context of entry into the injection may be a strategic time to intervene. Indeed, initiation to injection phase exposes to the sharing of preparation material for injection, major vector of transmission of HCV and shows a high exposition for young people. The Ministry of Health recommended exploring this new intervention's area including both actions to prevent transition to injection and actions for an initiation to injection at lower risk. A collective expertise of INSERM raised the English program *Break the Cycle* as an attractive example for developing this strategy. The objective of this study was to test the feasibility of the implementation of this strategy through the analysis of the adaptability of *Break the Cycle* to the French context. It aims at analyzing its integration within the existing French HR supply and more generally, to establish guidelines for developing a more effective intervention strategy to reduce HCV among IDU in France. The investigations during this first four-month period have targeted French actors' representations and practices of work in the context of entry into the injection to get a set of potential brakes and levers for the implementation of such a strategy. The efficiency of an HR intervention within this context compared to the reduction of HCV has not been assessed yet. An analysis of various experiments of *Break the Cycle* internationally has been done in order to obtain references to eventually adapt the intervention to the French context. Then, a qualitative census of practices, representations and expectations of French actors on the different aspects of entry into the injection was conducted in five major French cities. Additional data have been collected during the first meeting of the French actors whose aim was to bring together key actors to develop the conditions for a co-construction of this strategy. The first major result of investigations showed that a collaborative development of this strategy is required but its development in its entirety may be hampered by a lack of recognition of the HR approach in the French health policy and by other barriers disconnected from any scientific approach. In addition, before developing this new strategy, important needs must be covered, such as strengthening the training of HR workers and facilitating exchanges around injection practice in proximity structures. A better understanding of the subject is a prerequisite also. More precisely, interventions in this context might be integrated into a wider range of tools, to give a response to all variety of needs and profile among DU. The use of the method of transition to other modes of administration is seen as relevant, even though regular injectors are best suited and the training of workers will have to be updated. The analysis of countries which have adapted *Break the Cycle* shows that the adaptation of the intervention's tools to the local culture and the cooperation with users and self-support groups are

required to get a sustainable implementation. Its articulation with other local programs and a sustainable financing might lead to a successful implementation. An integrated version with an alliance between education to injection, prevention of injection and initiation at lower risk seems to contribute to success. In France, *Break the Cycle*'s experimentation depends strongly upon the agreement of HR self-support groups, local services and users. It might be adapted in consultation with all stakeholders. This partnership in progress should be strengthened in the coming months. The role of INPES in this project is another important element to specify in the coming months. The French version should be integrated into a wider range of approaches to intervene at the time of a potential initiation to injection, upstream and within a regular practice. It might respect the initial peer-based approach. Raising awareness among injectors about the risks in order to push them to protect others might be its main purpose. This program might promote the exchange around the injection and must target people at high risk. Finally, *Break the Cycle*'s efficiency should be proven ultimately by a scientific assessment regarding the objective of reduction of HCV among IDUs.

RESUME

En 2009, la prévalence du Virus de l'Hépatite C (VHC) chez les Usagers de Drogues (UD) en France est comprise entre 40 et 50% tandis que pour le VIH, elle se situe entre 6 et 8%. La voie intraveineuse est reconnue comme la pratique la plus à risque en termes de VHC. L'endiguement de ce phénomène est donc une priorité de santé publique pour le Ministère de la Santé et pour les acteurs français de Réduction Des Risques (RDR). L'offre française actuelle de RDR a démontré un impact positif sur la réduction du VIH, mais ne se montre pas aussi efficace pour endiguer le VHC. Le contexte de l'entrée en l'injection est un moment stratégique pour intervenir en faveur de la réduction du VHC car il expose davantage les usagers au partage du matériel d'injection, vecteur de transmission majeur du VHC et met en scène un jeune public. Le Ministère de la Santé a donc recommandé l'étude de ce contexte suite à l'expertise collective menée par l'INSERM. Ce nouveau domaine d'intervention comprend à la fois des mesures pour prévenir le passage à l'injection et des actions en faveur d'une initiation à l'injection à moindre risque. L'expertise de l'INSERM a désigné le modèle du programme anglais *Break the Cycle* comme un exemple d'interventions à étudier. Le but de cette étude est d'établir des premières recommandations pour l'élaboration d'une stratégie plus efficace pour réduire le VHC chez les injecteurs en France qui s'appuierait sur l'entrée dans l'injection. L'objectif est de tester la faisabilité de sa mise en œuvre à travers l'analyse de l'adaptabilité du programme anglais *Break the Cycle* au contexte français et à analyser son intégration dans l'offre française de RDR. Le dispositif d'enquête au cours de cette première période de l'étude ont ciblé les représentations et les pratiques professionnelles dans le contexte de l'entrée dans l'injection. L'efficacité d'une intervention dans ce contexte n'a pas été évaluée pour l'instant par rapport à la

réduction du VHC. Une analyse des expériences de *Break the Cycle* dans le monde a été réalisée afin d'obtenir des références pour son adaptation locale. Puis, un recensement qualitatif des représentations et des attentes des acteurs français a été réalisée dans cinq grandes villes françaises. Enfin, un recueil de données supplémentaires a été effectuée au cours de la première réunion des principaux acteurs locaux pour établir les conditions d'une co-construction de cette stratégie. Le premier résultat majeur de l'enquête montre que la concertation entre les acteurs autour du développement de cette stratégie est une nécessité. Le renforcement de l'articulation des acteurs autour de sa mise en place est un premier objectif à atteindre même si le manque de reconnaissance de l'approche de RDR dans la politique de santé française entrave probablement cet aspect. D'autres obstacles (sémantiques, historiques, «idéologiques», etc.), déconnectés de toute démarche scientifique semblent également faire obstacle à son développement dans son intégralité. Avant de s'engager dans le développement de cette nouvelle stratégie, les acteurs pensent que d'importants besoins doivent être couverts en France. Le renforcement de la formation des intervenants de proximité et faciliter l'échange autour de la pratique d'injection dans les structures de première ligne sont des pré-requis. En outre, une meilleure compréhension du sujet est une autre étape préalable. Plus précisément, toutes les actions relatives à cette stratégie doivent être intégrées à un large éventail d'outils, afin de pouvoir proposer une réponse à l'ensemble des besoins et profils des usagers. L'utilisation de la méthode de transition vers d'autres modes d'administration est encouragée même si un public d'injecteurs réguliers, semble plus adapté selon les acteurs. Cette méthode exigera probablement la mise à jour de la formation des intervenants aussi. Une coopération avec les personnes plus susceptibles d'être présentes au moment de la première injection (les pairs, les équipes du milieu festif) est un autre point important. L'analyse des différentes expériences de *Break the Cycle* à l'échelle internationale montre que l'adaptation des outils d'intervention à la culture locale est une nécessité pour une implantation durable. La coopération étroite avec les groupes d'auto-support et les services locaux dès les premières étapes d'adaptation est une autre condition majeure. L'articulation du programme avec les programmes locaux et un financement durable semble également contribuer à sa pérennité. Les versions intégrées (éducation à l'injection, prévention de l'injection, initiation à faible risque) ainsi que l'approche par les pairs sont des éléments favorables à la réussite de plusieurs expériences. La version française de *Break the Cycle* devra donc être intégrée à un large éventail d'approches pour intervenir au moment de l'initiation, en amont et dans le cadre d'une pratique d'injection régulière et répondre ainsi à l'ensemble des profils des usagers. L'approche par les pairs doit être envisagée également. Le processus d'adaptation doit se faire en concertation avec les utilisateurs et l'ensemble des acteurs de RDR. La sensibilisation des injecteurs sur les risques et les aider à appréhender un rôle protecteur vis-à-vis des autres est un objectif à privilégier. Pour finir, l'efficacité de *Break the Cycle* devra être évaluée dès la phase « pilote » par des organismes scientifiques en termes de réduction du VHC parmi les UDVI.