# VAD-studiedag - postersessies

Op vrijdag 22 november 2024 organiseert het Vlaams Expertisecentrum Alcohol en andere Drugs zijn jaarlijkse studiedag in het Vlaams Parlement. Van 9u30 tot 13u hebben diverse sprekers het over de impact van lokale initiatieven in preventie en hulpverlening op het beleid.

Tijdens en na de lunch zetten we enkele van deze lokale initiatieven in de kijker. Met boeiende 'postersessies' bieden we deze initiatieven een platform om hun werk te promoten en anderen te inspireren. Ook interessante onderzoeken rond onze thema's kunnen een plek krijgen. Wil jij erbij zijn? Lees dan de instructies hieronder.

## Hoe doe je dat, zo'n postersessie?

Met een postersessie kun je je werk op een toegankelijke manier presenteren aan een breed publiek en krijg je meteen de kans om te netwerken. Het doel is dat geïnteresseerden je initiatief op een informele manier leren kennen.

Wat heb je daarvoor nodig?

- Een boeiend lokaal en/of regionaal initiatief binnen preventie of hulpverlening of onderzoeken naar relevante VAD-thema's;
- Een poster (afmetingen 100 X 65 cm, A1, staand) die kort, krachtig en bij voorkeur visueel de werking van je initiatief samenvat;
- Eventueel extra promomateriaal om uit te delen aan deelnemers.

Wij bieden gratis toegang tot de studiedag, inclusief lunch, een plek voor jouw presentatie, en een geïnteresseerd publiek!

Op zoek naar een programma waarmee je aan de slag kan om je poster te maken? Kijk dan eens hier.

Inspiratie nodig? Deze website kan je al helpen.Op de volgende pagina's vind je ook een paar voorbeelden van gelijkaardige posters.

## Interesse?

Werkt jouw organisatie aan een boeiend project en wil je het werkveld er meer over vertellen? Laat het ons weten **vóór 15 september**! Stuur een mail naar vormingenadministratie@vad.be met volgende informatie:

- Naam van het initiatief
- Naam/namen van de personen die deze sessie willen voorzien
- Een korte beschrijving van het initiatief

## Nog vragen?

Stuur je vraag naar vormingenadministratie@vad.be. We helpen je graag verder.

In Flanders, Belgium, despite the existence of evidence-based interventions targeting one or more steps along the chronic HCV care continuum, **we see many undiagnosed infections and poor treatment uptake among People Who Use Drugs (PWUD) .** The existing examples of good clinical practices remain mostly operational on a local level only and often under the impulse of a few dedicated individuals, leading to **large inequalities in access to HCV care.**

# EXPERTC, A PILOT IN BUILDING A CARE CASCADE FROM THE GROUND UP.

**Windelinckx T** - Ngo Free Clinic Belgium , **dr. Verlinden W** - AZ Nikolaas Belgium, **dr. Schouten J** - AZ Nikolaas Belgium, **dr. Matheï C** - Ngo Free Clinic and KULeuven Belgium

## Situation Sint-Niklaas january 2018

Hometown of an old population of PWID (People Who Inject Drugs)
Young PWID - no/limited contact with healthcare workers.

a small town
between Antwerp and Ghent.
population76000

GP's

2 **hepatologists** local hospital,

3 **outreach workers** - not exclusively working with PWUD.

**Small low threshold drugcentre** healthcareworkers/ GP consultation - one afternoon a week. (since 1999)

**# Hepatologists have limited contacts with PWUD's**
**# No link between the hepatologists and the outreachworkers /GP of the drugcentre.**
(situation in January 2018)

**In january 2018 we established a pilot project in Sint Niklaas, called 'ExpertC'.**
**The goal: 'to transfer knowledge and expertise of evidence-based methodologies and good clinical practice to facilities involved in care for PWUD'. This in order to increase awareness and testing, to ensure access to HCV treatment and eventually link PWUD to care.**

**These action points were addressed, encouraged, adapted and supported to local needs. The first assignment of the ExpertC pilot consisted of the assessment of the present situation and the identification of local needs. The second action point was to bring theory into practice. Through outreachwork, one day a week PWUD were contacted, screened and referred to the new established network.**

**Hepatologists:** expressed their willingness to treat PWID's as patients more intensively.

**The GP of the low threshold centre**, was eager to participate in the project. Specifically: to inform his clients about the ExpertC project, refer clients to screening and work together with the hepatologists in the context of the project.

Other **local GP's** and organisations were contacted, gauging their contacts with PWID and their knowledge and needs concerning hepatitis C.

All **GP's** referred to the low threshold drug centre, outreach and a local health centre 'De Vlier'. But the overall message was: they do not encounter PWID in their offices.

In a meeting with **outreach workers**, their role in the care cascade was pointed out and information on HCV was transmitted. Outreach workers were interested in referring their clients to the ExpertC-pilot project, aiming for screening and access to the care cascade.

**'De Vlier'** only had 1 or 2 patients with hep C, but expressed the need for contact with local hepatologists to increase knowledge and to exchange patients.

A **justice department** was also contacted, given information on HCV and the ExpertC-pilot project. Here as well, the need for more training became apparent.
Finally, prior to the start of the pilot, the **local police** department and the **local government** were notified.

## A low threshold-based trajectory was created, ensuring an easy access for PWID to a PCR , followed by a consultation with a hepatologist.

**PWID were contacted in the low threshold centre, via outreach or referral (**mainly by outreach workers and the justice department).

An **antibody(Ab) screening (by means of finger prick) was performed on site**, including pre- and post-counselling including an informed consent.
PWID who were screened, completed a questionnaire afterwards.

**PWID with a positive AB-status were taken to the hospital to deliver a blood sample for a PCR-test. Herefore, no appointement was necessary,** using pre-written blood sample forms.

**Finally, an email was sent to the hepatologists, in order to schedule a consultation two weeks later, with ultrasound and elastography.**

Remark: PWID had the right to enter the care cascade free of charge, without personal costs (full reimbursement).

**The ExpertC-pilot project ran 6 months from January to July 2018 – one day a week.**
**... and we implemented the local care cascade!**

**The local health centre** 'De Vlier' will screen and refer PWUD.
The **GP** of the low threshold centre will screen and refer to the **hepatologists**.
**Outreach** is informed and will refer to screening and treatment.
Follow-up during treatment will be taken up by both the low threshold centre and outreach work
**Needle exchange** is established in 2018 and will organise a yearly **HCV 'awareness-week'** in Sint Niklaas

## Operational results - Expert C - overall

**The screened population:**
Mean age: 41,7 years range (24y-62y)
Gender: 73,7% male PWUD
Administration mode: 69,2% ever injected, 56,2% of them on daily basis
Current use: 23% recently injected

**Screening figures: (N=15)**
9 PWID scored a negative result on the antibody test
9 PCR were performed:
- 4 PWID were RNA-positive
  - 2 PWID: started treatment during the pilot
  - 1 PWID: liver cirrhosis and two tumours in the liver, the tumours were treated and he will start treatment
  - 1 PWID: liver damage limited to F1-level, therefore not applicable for DAA treatment yet
- 3 PWID were cured or spontaneously cleared in the past and still remain RNA negative
- 1 recent re-infection
- 1 waiting result

## Case 1: 'mr E.' cirrhosis

**Medical history**
# Former PWID - Stopped injecting in 2008
# Positive HCV AB-test, prior to 2000
# First confirmed HCV RNA test in 2008
# Drinks at least 4–5 units of alcohol daily
# Daily cannabis use
# Occasional cocaine use (snorting)
# No contact with drug service, no OST (Opioid Substitution Therapy)
# Visits GP regularly

**Diagnosed with HCV prior to 2000**
# 2008 Positive HCV PCR test
# Only IFN (interferon)-based therapy available
Conditions for treatment initiation set by treating physician: Mr. E had to prove abstinence from both alcohol and other drugs during 6 months
# Not feasible for Mr. E.
# 2008 - 2018:
# follow-up was abandoned
# Regular GP visits only

**2018**
# **January**: Mr. E. is brought into contact with ExpertC-pilot project by outreach work
# **April**: Mr. E is encouraged to undergo an HCV RNA test (new PCR after 10 years) Showed fearful of a blood test
# May: Mr. E present at first consultation with hepatologist, accompanied by social worker
- Chronic HCV confirmed
- Diagnosed with compensated liver cirrhosis and liver nodules
- MRI and CT scans scheduled to rule out liver cancer

# **June**: Mr. E's CT scans and MRI results are available
- Two tumours in the liver
- Motivational talk and support needed to convince Mr. E that further examinations were necessary and urgent
- CT scan of lungs and bone scan, gastroscopy and blood tests were executed despite difficulties with venal puncture (due to vein damage)

# **June**: Mr. E receives 'good news'
- No metastasis in bones or lungs
- Message from hepatologist: "you're on the right track, keep going at your own pace"
- Mr. E reduced alcohol consumption from 5 units to 1 unit a day
- Mr. E expresses ambition to stop alcohol use

# **July**: Establishing an action plan – what remains to be done and what is possible/realistic?
- Firstly: removal of the liver tumours
- Secondly, start of HCV treatment (once tumours have been treated)
- Finally, possible need for liver transplant in the long term?

## Case 2: 'Mr. O.' F1

**Medical history:**
# Former PWID
# Non injector since 1998
# Positive HCV AB-test prior to 2000
# 2018: RNA positive
# Drinks at least 7-8 units of alcohol daily
# Occasional cannabis use
# No contact with drug service, no OST
# Stable work situation
# Stable family situation

**May 2018:**
# Mr. O gets into contact via personal connection.

**June 2018:**
# RNA positive , liver damage F1
# Mr. O is not eligible yet for (new) DAA treatment due to policy regulations
# Mr. O has to be present at a yearly consult with the hepatologist
# Mr. O's partner (non-PWUD) tested negative on the antibody test

**With limited effort, we can convince the existing network of the importance of their role in the HCV-care cascade; we can guide PWUD towards the care cascade and upscale uptake in screening and treatment for hepatitis C and therefore close gaps.**

## The future
**We are aiming to implement the ExpertC-pilot project in the entire country (Belgium) and establish tailored HCV-care cascades, adapted to local needs and context.**

Please contact me for more information: www.free-clinic.be, Tessa.windelinckx@free-clinic.
"This project was financially supported by MSD Belgium bvba/sprl."

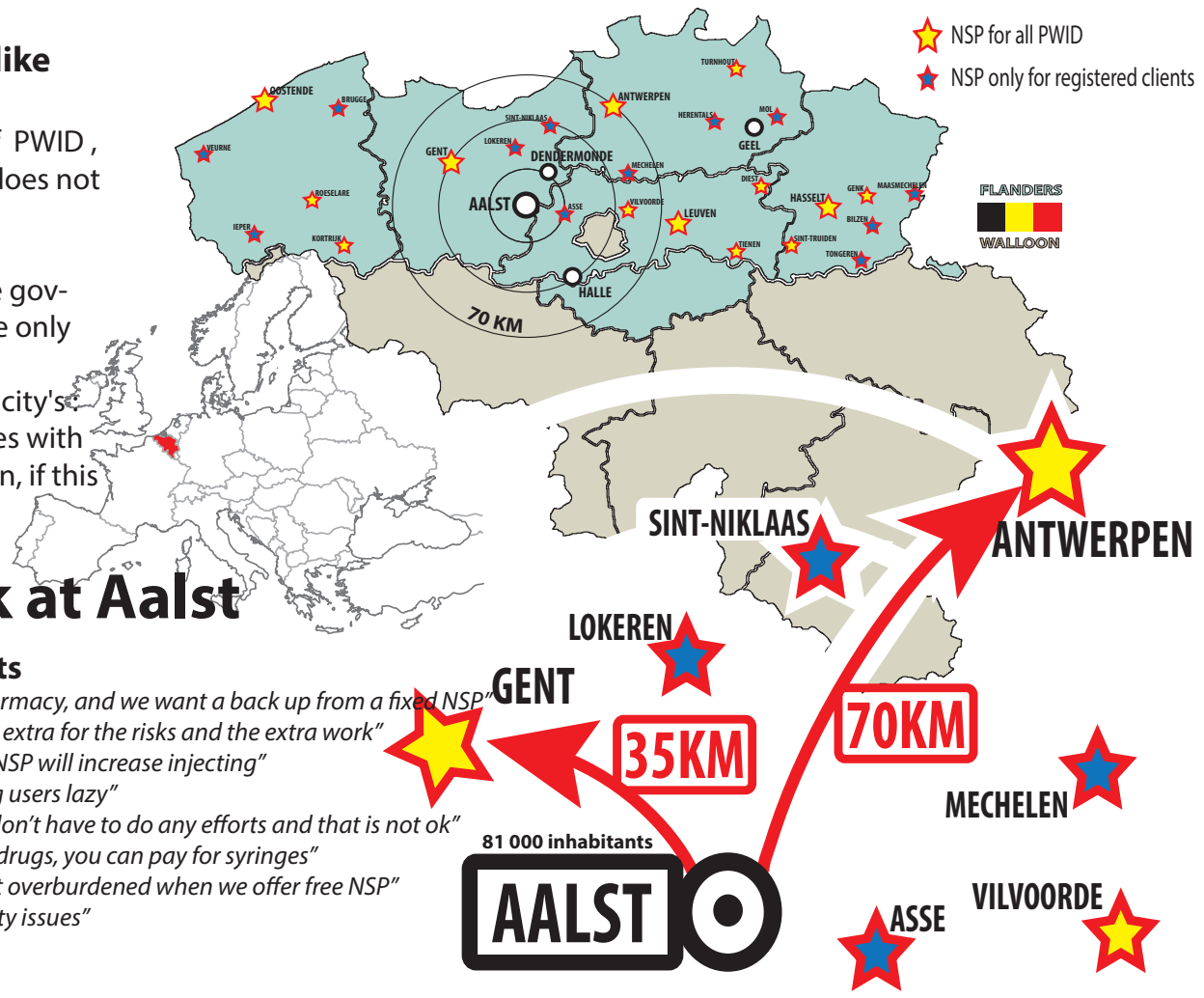
# Gym bags with dirty syringes

## "Serious gaps in local NSP coverage in Flanders Belgium"

According to the Global state of Harm Reduction 2012 (and the EMCDDA national reports) NSP exists in Belgium. NSP was introduced in 2001, has good figures and there is a 99% return rate. *"So far so good...!"*
When we zoom into the coverage we see that there are huge gaps in service delivery on local base: NSP is active in major city's and not always in smaller ones.

**PWID in smaller city's who want to use in a hygienic way are forced to travel more than 35 km. Many cases are reported from PWID who packed with gym bags travel to the nearby city's like Gent, Vilvoorde and Antwerp, to exchange their used needles.**

**Common reasons for having no NSP in smaller city's like Dendermonde, Aalst, Halle, Geel,... :**
- In Flanders we had **no major HIV outbreak** in the population of PWID , the prevalence since the start of NSP in 2001 is less than 5% and does not increase.
- **Lack of public health urgency**
- **Traditional conservative community and government**. These governements believe abstinence, prevention and repression are the only strategies to drug use.
- **Abstinence based treatment system** is most present in smaler city's: these services find it difficult to combine harm reduction strategies with their vision. In their opinion drug users first have to try to get clean, if this doesn't work, then harm reduction is the last solution.




## As a case study we take a look at Aalst

### The local drug service is abstinence based

*" NSP is not compatible with how we work and vision"*
*" we want drug users to stop using drugs"*
*"we want to reach abstinence"*
*" you can not offer NSP when people want to get clean"*

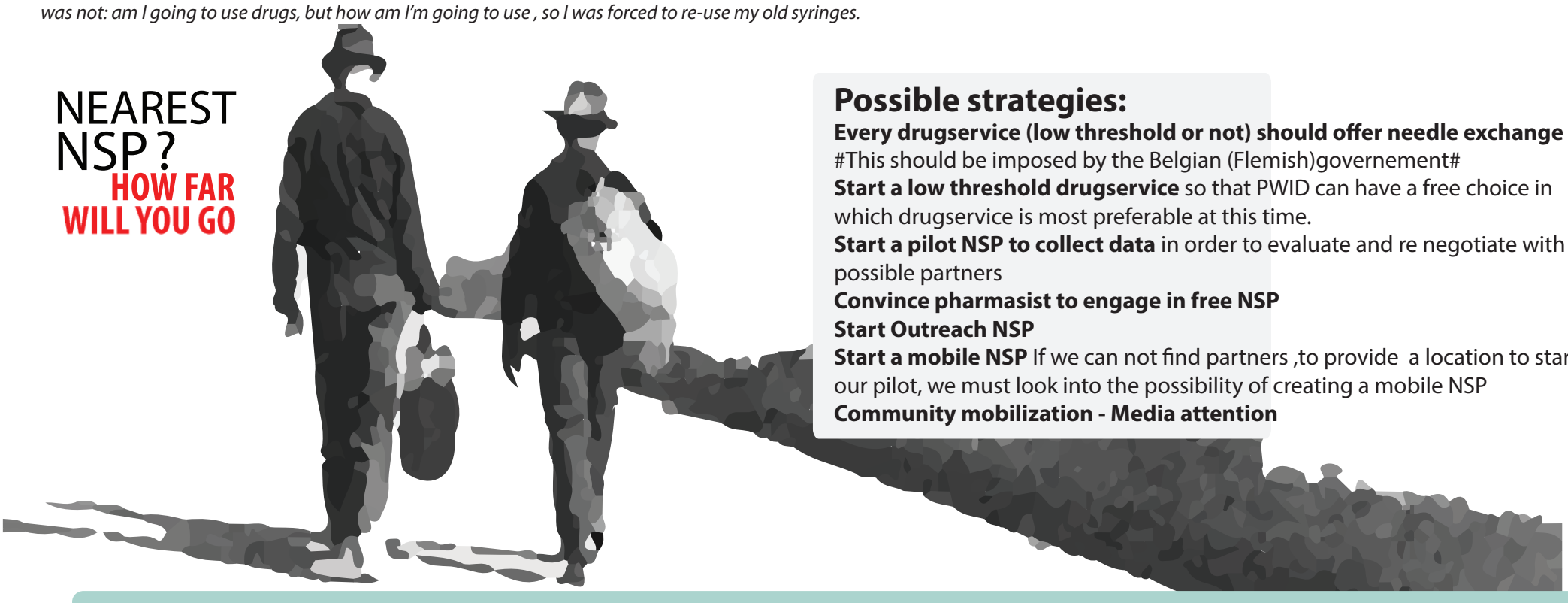
**There is no NSP, why ?**

### 29 pharmacists

*"not as the only pharmacy, and we want a back up from a fixed NSP"*
*"we don't get payed extra for the risks and the extra work"*
*"we are afraid that NSP will increase injecting"*
*"NSP can make drug users lazy"*
*"in NSP the PWID's don't have to do any efforts and that is not ok"*
*"when you can buy drugs, you can pay for syringes"*
*"we are afraid to get overburdened when we offer free NSP"*
*"we have some safety issues"*

### 150 PWID

*"I drove 2 to 3 times to Antwerp to get my dope and then I went to the NSP"*
*" there is a drug service in Aalst, but they expect that I quit using drugs, they have weekly urine-controls. I should have to quit using heroin, otherwise I should not get methadone"*
*" after I crashed my car I was forced to take the train, then I got several fines and was arrested with heroin… afterwards I took the bus, as a result I was travelling all day (but was never caught with dope and syringes on the bus"*
*"I was a dealer in Aalst and many times I saw that PWIDs are re-using old works and are sharing their works and this is not ok!"*
*Once I tried to exchange my old syringes in a local hospital and this was what the doctor said : " I can't give you clean syringes because this will facilitate your drug use" The question was not: am I going to use drugs, but how am I'm going to use , so I was forced to re-use my old syringes.*




### Possible strategies:

**Every drugservice (low threshold or not) should offer needle exchange** .
#This should be imposed by the Belgian (Flemish)governement#
**Start a low threshold drugservice** so that PWID can have a free choice in which drugservice is most preferable at this time.
**Start a pilot NSP to collect data** in order to evaluate and re negotiate with possible partners
**Convince pharmasist to engage in free NSP**
**Start Outreach NSP**
**Start a mobile NSP** If we can not find partners ,to provide a location to start our pilot, we must look into the possibility of creating a mobile NSP
**Community mobilization - Media attention**

**30 years after the HIV outbreak and implementation of the first NSP , we still have huge gaps in coverage. Even in high income countries like Flanders Belgium with well established drug- and harm reduction services, significant efforts are needed to (re-) invest in order to reach universal access to prevention materials. Both policy and drug services must be persuaded of the positive health outcome of NSP.**

Authors: Tessa Windelinckx (NSP Flanders, Free Clinic ngo) and John-Peter Kools (independant)

Data were obtained by NSP East Flanders and NSP Flanders, unpublished document More information : tessa.windelinckx@free-clinic.be
Report NSP Flanders 2012 and Evaluation report NSP Flanders 2012, T.Windelinckx, 2013,published on www.free-clinic.be

# TEST----TREAT ----------CURE

# WHY CASEMANAGEMENT IS NOT SUFFICIENT ANYMORE

# PWUD WITH MULTI PROBLEMS NEED CAREMANAGEMENT

# PUWID HEP CAREMANAGEMENT

N=150

| | |
|---|---|
| Need high level of support | 62,4% |
| No social network | 48,4% |
| Alcohol abuse | 63,0% |
| IV druguse during treatment | 53,0% |
| Mental health issues | 48,5% |
| Poor general health condition | 45,0% |
| Fysical co-morbidity | 71,4% |
| No income | 13,7% |
| Social benefits income | 76,3% |
| No permanent housing | 32,1% |
| Living in homeless shelters | 05,0% |

## 'The Antwerp model'

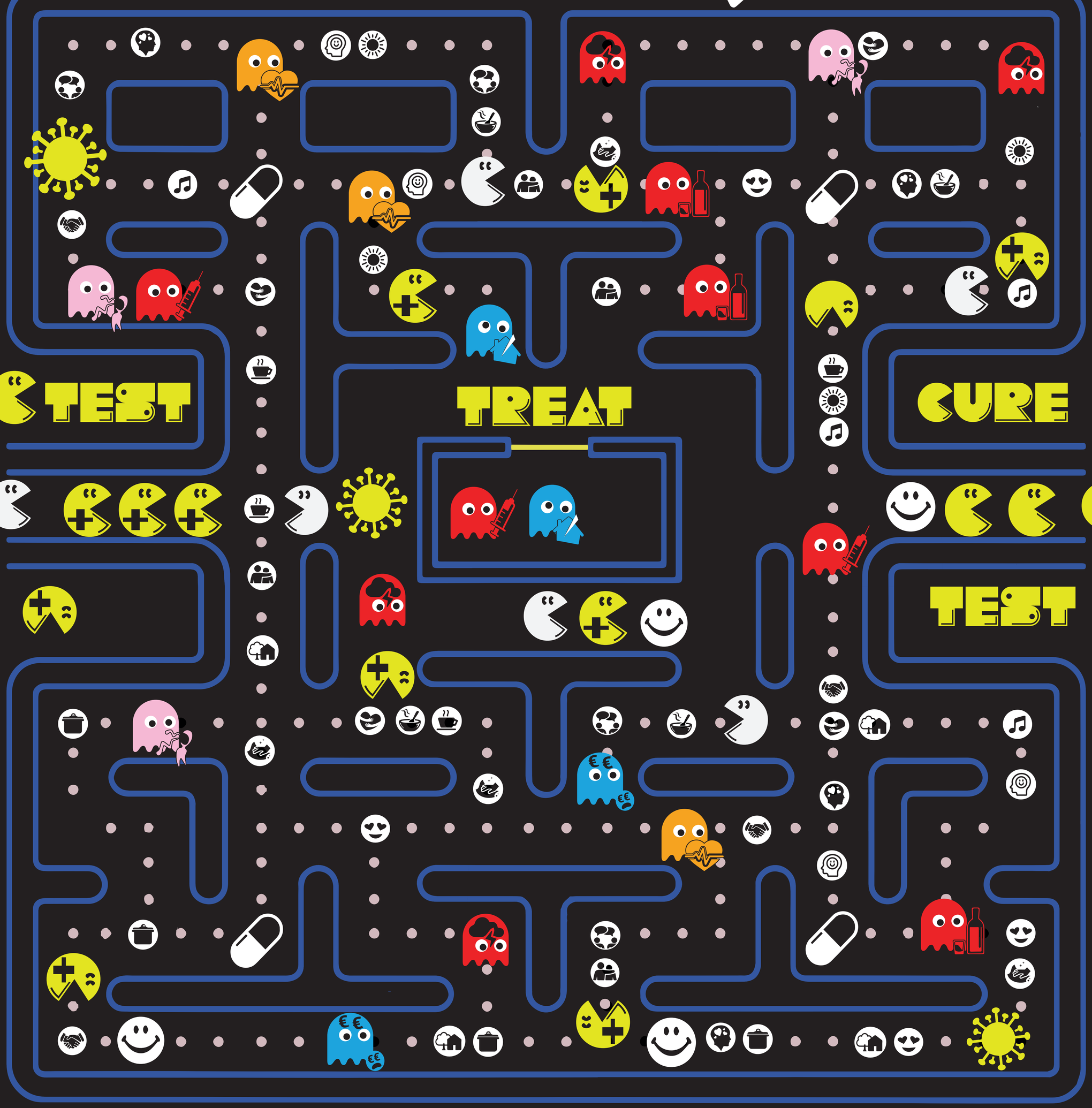
is a strong cooperation between FREE CLINIC ngo (low-threshold service for PWUD, from **HARM REDUCTION** perspective) and ZNA COMMUNITY HOSPITAL, in order to OFFER HCV CARE to EVERY PWUD.

In the early days of interferon we have treated the most motivated, during the first years of DAA we treated the sick (F3,F4), and later on the easiest to catch.
Since a few years we've noticed that it's not easy to get people to treatment and when linked to care as we are confronted with multiple problems on different levels.

**conclusion...**

## PWUD WITH MULTI PROBLEMS NEED GLOBAL MEDICAL AND NON-MEDICAL SUPPORT...

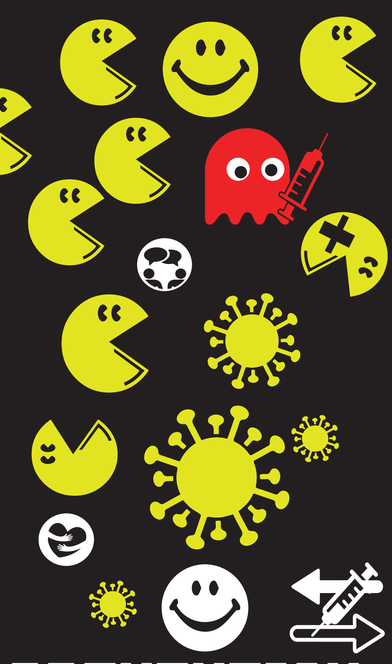
## BASED ON A TRUE AND COMPLEX STORY




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


WE SUPPORT

LIFE GOES ON



PREVENTION OF REINFECTION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