The role of civil society in successful testing and linkage to care

A little kindness costs nothing

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HepHIV 2017 Conference

Ms. Swan has no financial relationships to disclose

OVERVIEW

- Civil Society – who are we?
  - What we do (focus on HCV)
- Why is it difficult?
  - Structural Stigma, Barriers
- What systems are we linking people to?
- Guidelines and evidence
- A case study
- Questions and ideas

WHAT IS CIVIL SOCIETY ?

Civil society is the “third sector” of society, along with government and business. It comprises civil society organizations and non-governmental organizations.

People living with, or at risk for HIV and HCV (and their allies), many from vulnerable, marginalized groups, who draw from their experience to fight for human rights and access to quality health care.

What do we do

Meet people 'where they are'

Outreach, peer support, education, counseling, testing- 'safe space', low- threshold HR services including NSP and OST

Fight for universal access to HCV treatment- especially for people who inject drugs!

WHAT ARE WE UP AGAINST?

MANY OF THE PEOPLE THAT WE WORK WITH ARE UNDER PRESSURE; EVERY DAY, THEY DO THINGS THAT ARE NOT LEGAL

MANY OF THE SYSTEMS WE ARE LINKING THEM TO ARE NOT ADAPTED TO THEIR NEEDS

80% OF NEW INFECTIONS OCCUR AMONG CURRENT PWID

PEOPLE LIVING WITH HCV INFECTION

Slide Courtesy of Greg Dore, Kirby Institute NSW

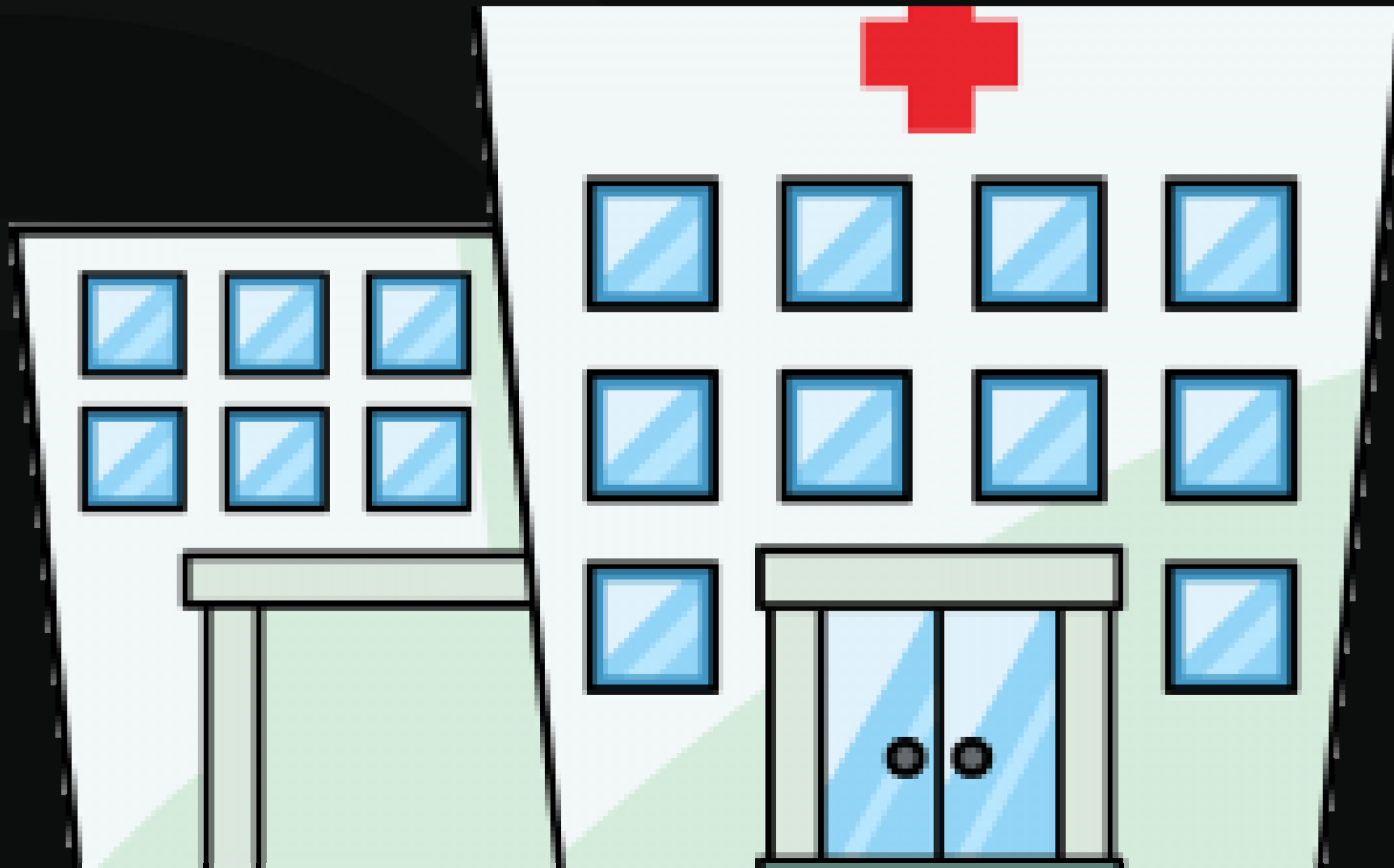
60% OF EXISTING INFECTIONS ARE AMONG CURRENT & FORMER PWID

PEOPLE LIVING WITH HCV INFECTION

Slide Courtesy of Greg Dore, Kirby Institute NSW

Structural stigma refers to the rules, policies and procedures of institutions that restrict the rights and opportunities for members of stigmatized groups

Livingston et al; Addiction 2012. Corrigan et al; Appl Prev Psychol 2005; Corrigan et al; John Wiley & Sons 2011



What are we linking people to?

"…. a primary structural barrier to treatment uptake is the hospital based setting, both for its inconvenience, lengthy waiting times and rigid eligibility criteria, but also due to the stigma and discrimination many participants reported experiencing. "

World Health Organization. Barriers and facilitators to hepatitis C treatment for people who inject drugs. .A qualitative study . 2012

What is the typical amount of time spent in the waiting room ?

1. Less than 15 minutes
2. Less than 30 minutes
3. Less than 45 minutes

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Will they get what they are waiting for?

CO-STAR: an evidence base

- 301 HCV TX-naïve
- OST for at least 3 months, adherent to at least 80% of clinic visits
- 58% had positive drug test at baseline

Dore, et al; EASL 2016

Immediate-Treatment Group (ITG)

EBR/GZR, n = 201 | Unblinding | Follow-up for 24 weeks

Deferred-Treatment Group (DTG)

Placebo, n = 100 | Unblinding | EBR/GZR† | Follow-up for 24 weeks

Dore, et al; EASL 2016

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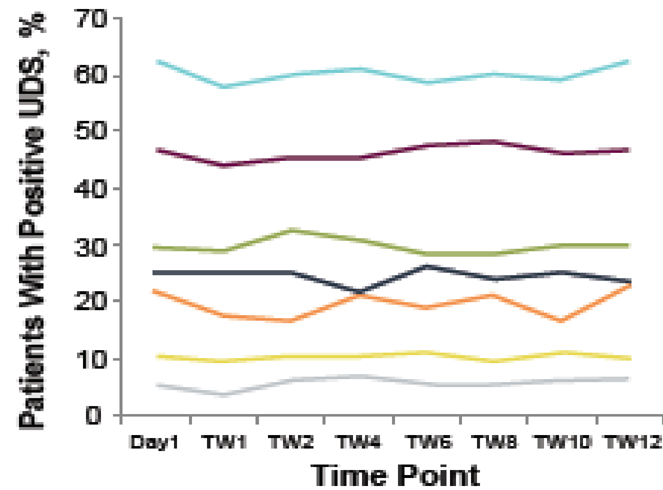
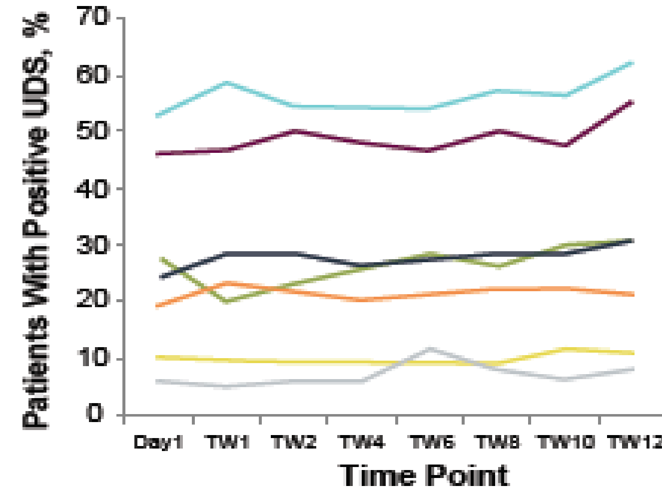
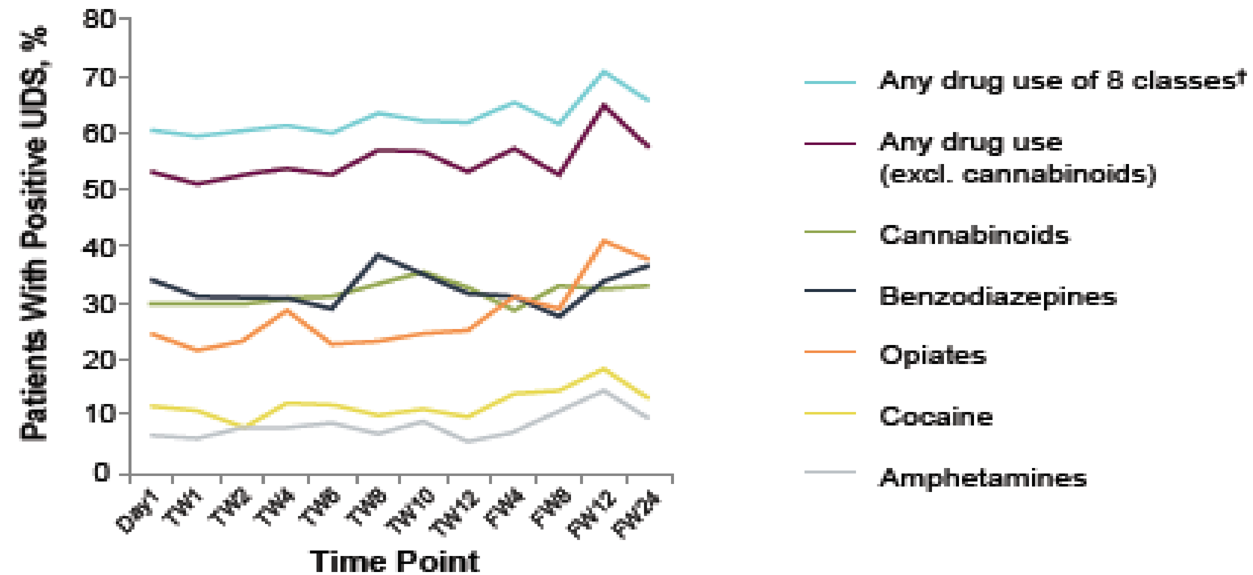




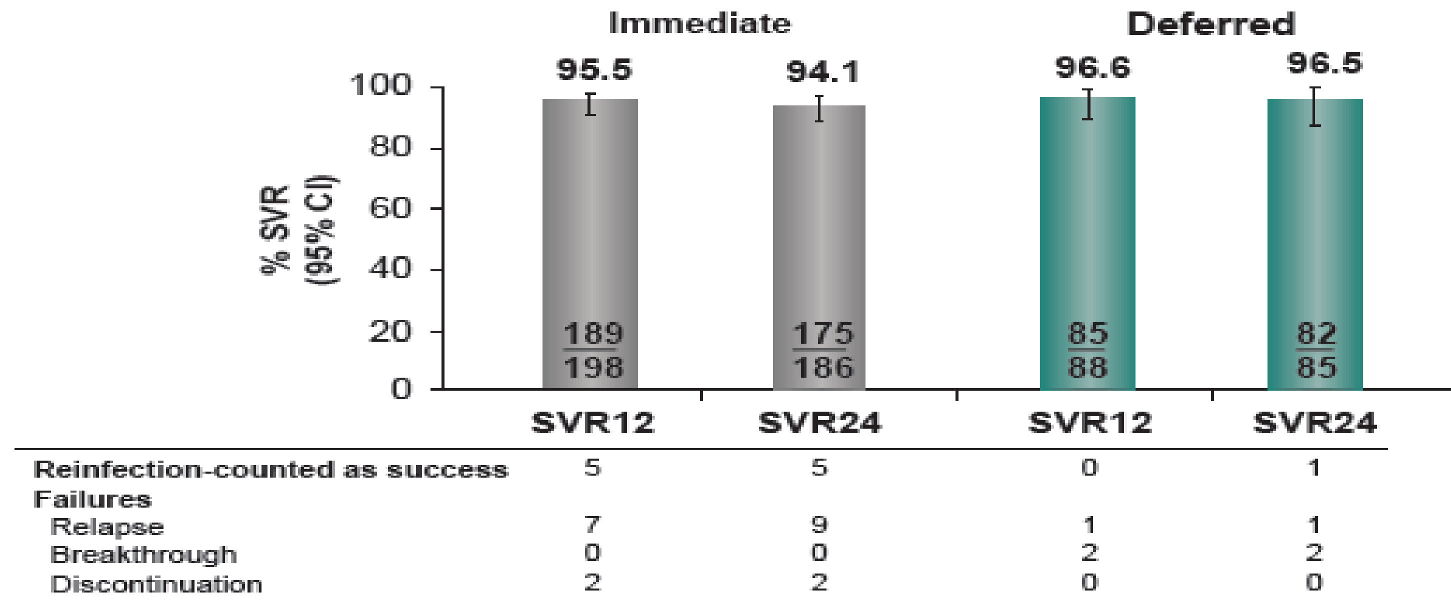


Dore, et al; EASL 2016

Virologic Response

- In the mFAS, SVR was >94% at FW12 and 24 in both the ITG and DTG (**Figure 4**)
  - In the full analysis set (where discontinuations were counted as failures—see Figure 3), SVR12 was 91.5% in the ITG and 85.6% in the DTG, and SVR24 was 89.5% in the ITG and 85.3% in the DTG

Figure 4. SVR12 and SVR24 (mFAS)



	SVR12	SVR24	SVR12	SVR24
Reinfection-counted as success	5	5	0	1
Failures				
Relapse	7	9	1	1
Breakthrough	0	0	2	2
Discontinuation	2	2	0	0

CI, confidence interval.

Dore, et al; EASL 2016

Dore, et al; EASL 2016

Among 1952 patients enrolled in the ION studies:

4% (n=70) were receiving OST.

Among those receiving (n=70) and not receiving OST (n=1882), **there was no difference in treatment completion** (97% vs. 98%, *P*=0.40) **≥80% adherence** (93% vs. 92%, *P*=1.00), **SVR12 (94% vs. 97%, *P*=0.28**), and serious AEs (4% vs. 3%, *P*=0.43), respectively. Among participants in the ION-1 trial, 23% (n=196) used illicit drugs during therapy

Grebley et al; CID 2016

HCV

treatment must be considered for PWIDs who are willing to receive treatment, are able and willing to maintain regular appointments and adherence, and accept to undergo integrated management of their substance abuse, including syringe exchange program, substitution therapy and other general harm reduction strategies.

EASL. Recommendations on Treatment of Hepatitis C 2016.
http://www.easl.eu/medias/cpg/HCV2016/English-report.pdf

PROJECT HOPE

Hospital Visit as Opportunity for Prevention and Engagement for HIV-infected Drug Users

11-state, NIDA-sponsored trial in 801 hospitalized HIV+ people, who were not engaged in HIV care and heavy alcohol and/or stimulant/opioid users

- Median VL 56,658 copies /mL
- Median CD4 cell count 110 cells/uL
- 89% had income of <$20,000 year
- 78% had been in jail
- 66 male / 32 female/2 transgender
- 78% black/19% white/ 4% other/ 11% Hispanic

Metsch et al; JAMA 2016

COMPARED 6 Months of:

Navigation brought people to HIV care & drug treatment, provided support, counseling w/ stages of change theory (up to 11 sessions)

Navigation + incentives for visiting doctor, drug treatment, being drug-free with a bonus for viral suppression /drop in viral load (median incentive US $722)

TAU Written referrals, appointment scheduling

Metsch et al; JAMA 2016

OUTCOMES (among 92%)

At 6 months, viral suppression was achieved by:

50.4% navigation + $

43.1% navigation only

38.2% TAU

At 12 months, there was **no difference** in viral suppression or mortality rates (11%)

Metsch et al; JAMA 2016

What does this study tell us:

1. Paying people who use drugs is the best way to keep them linked to care and treatment
2. The challenges that people who use drugs face make it difficult for them to stay in care
3. Prolonged interventions will be more effective than short-term ones

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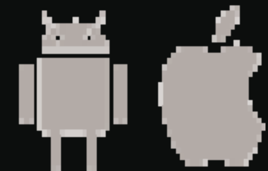

OR MAYBE…..

they weren't comfortable with the way their health care was delivered……. that might be part of the reason why they stopped going in the first place

What services are available to people who inject drugs in your locale?

Have you visited any?

Where do people who inject drugs go for health care in your community? Do you/does your site provide it?

Are you comfortable with/used to treating people who inject drugs?

If not, do you have a good referral?

Broaden the spectrum of traditional health care (when legal – and fight to do so when it isn't)

- Offer/provide injection equipment, naloxone, OST, reproductive health and primary care services under one roof
- Involve peers in design, implementation and oversight of services
- Consider flexible hours/scheduling

CONCLUSION

Communication and collaboration between stakeholders strengthens linkages, improves treatment outcomes

- ‘nothing about us without us’