Harms and harm reduction workbook 2019

France

Contributors
Anne-Claire Brisacier, Cristina Díaz-Gómez, Magali Martinez (OFDT)

2019 National report (2018 data) to the EMCDDA by the French Reitox National Focal Point

Supervision: Julien Morel d'Arleux
Coordination and editorial: Aurélie Lermenier-Jeannet, Anne de l'Eprevier and Julie-Émilie Adès

Contribution to the workbooks
1. *Drug Policy*: Cristina Díaz-Gómez, Julie-Émilie Adès
2. *Legal Framework*: Caroline Protais, Cristina Díaz-Gómez, Aurélie Lermenier-Jeannet
3. *Drugs*: Olivier Le Nézet, Magali Martinez, Clément Gérome, Julie-Émilie Adès, Stanislas Spilka, Michel Gandilhon
4. *Prevention*: Carine Mutatayi
5. *Treatment*: Christophe Palle, Anne-Claire Brisacier
6. *Best Practice*: Carine Mutatayi, Anne-Claire Brisacier, Christophe Palle
7. *Harms and Harm Reduction*: Anne-Claire Brisacier, Cristina Díaz-Gómez, Magali Martinez
8. *Drug Market and Crime*: Michel Gandilhon, Magali Martinez, Aurélie Lermenier-Jeannet, Victor Detrez
9. *Prison*: Caroline Protais, Anne-Claire Brisacier, Julien Morel d'Arleux
10. *Research*: Maitena Milhet, Isabelle Michot

Proofreading (French version): Julie-Émilie Adès, Julien Morel d'Arleux (OFDT); Nicolas Prisse, president of the Interministerial Mission for Combating Drugs and Addictive Behaviours, and the project managers of the MILDECA
Proofreading (English version): Anne de l'Eprevier
Bibliographic references: Isabelle Michot
Legal references: Anne de l'Eprevier

Table of Contents

T0. Summary

Please provide an abstract of this workbook (target: 1000 words) under the following headings:

- National profile and trends harms
  Drug-related deaths: number, characteristics, trends and patterns
  Emergencies: number, characteristics, trends and patterns
  Drug related infectious diseases: notifications and prevalence incl. trends
- National profile and trends harm reduction
  Main policies and strategies directed at reducing drug-related health harms; availability, geographical distribution of services, and access:
- New developments

- National profile and trends harms

The number of overdose deaths in 2016 amounted to 309 among 15-49-year-olds (463 in total) according to the latest available data of the general death register. In 2017, 537 deaths were registered in the specific registers (432 in DRAMES added to the 105 deaths of DTA). According to the specific overdose death register (DRAMES scheme), 432 overdose deaths were registered in 2017 with opiates implicated in 78% of cases. Opioid substitution medications were implicated in 45% of cases and heroin in 25% of cases. Cocaine was involved in 26% of deaths. Otherwise, the mortality cohort study included 1,134 individuals, and for 955 (or 84%) of these subjects, the vital status was checked in December 2015. For men, the standardised mortality ratio was 5.6. For women, it was much higher (18.5).

The number of overdose deaths in the general death register has sharply risen (+31%) among 15-49-year-olds in 2016 compared to 2015. Between 2010 and 2016, opioid substitution medications were the main substances implicated in overdose deaths, ahead of heroin. Cocaine involvement is on the rise in deaths related to drug use since 2014.

Nearly 13,000 hospital emergency presentations related to drug use were reported in France in 2015 (Oscour® network). More than a quarter of presentations were related to cannabis use and less than a quarter to opioid use, whereas cocaine was implicated in 7% of cases, other stimulants in 3% of cases, hallucinogens in 4% of cases and, lastly, multiple or unspecified substances were responsible in 36% of cases.

In 2017, people infected through intravenous drug use represented 2% of new cases of HIV infection. The number of HIV seropositive diagnoses associated with drug use has been declining since 2010. The number of new AIDS cases related to drug use is also steadily declining since 2010.

Furthermore, between 2012 and 2017, the reported prevalence of HIV and HCV remained stable, both in the harm reduction facilities (CAARUD) and specialised drug treatment centres (CSAPA) context. This stability highlights the end of the declining prevalence of HCV among injecting drug users (IDU) observed since the beginning of the 2000s. The most recent data on biological prevalence are from 2011. The biological prevalence of HIV among drug users having injected at least once in their life was 13.3%, while the biological prevalence of HCV in this population reached 63.8%. The seroprevalence of AgHB (which indicates chronic hepatitis B virus infection) was 1.4% among drug users surveyed in the Coquelicot survey from 2011 to 2013.

- National profile and trends harm reduction

Harm reduction (HR) measures are intended for vulnerable populations whose substance use patterns expose them to major risks. These are notably based on the distribution of sterile single-use equipment (syringes, crack pipes, snorting equipment, injection and inhalation kits, etc.) and the diffusion of opioid substitution treatment. Preventing infectious diseases also relies on encouragement to undergo screening for HIV, HBV and HCV, as well as HBV vaccination and HCV treatment. Another major objective of HR measures is to promote drug user access to treatment and social benefits (accommodation, training, employment, etc.), particularly for the most destitute and socially isolated individuals.

Approximately 12 million syringes were distributed or sold to drug users in France in 2016. It was estimated that 9.8 million syringes were distributed in 2011 (last year available before the discontinuation in collated data). This development represents an 18% increase (i.e. an increase of 2.2 million syringes between 2011 and 2016). Pharmacy syringe sales in the form of injection kits, which represent a third of syringes distributed to drug users in 2016, fell by a third in 5 years (a 33% reduction between 2011 and 2016, i.e. 1 million fewer syringes), offset by the increase in distribution in specialised drug treatment centres (CAARUDs) (+37% in 5 year), harm reduction facilities (CSAPAs) (+20% in 5 years), automatic distribution machines (+47 in 5 years) and postal Needle and Syringe exchange Programme (+95% in 5 years).

- New developments

Updated guidelines on the management of HCV-infected individuals, and on the HIV screening strategy urge the continuation and consolidation of action already taken along these lines, particularly among injecting drug users. 59,000 patients suffering from chronic hepatitis C were treated and cured by direct-acting antivirals (DAA) between 2014 and 2017, including at least 11,000 former or current drug users. During 2017, reimbursement of DAA (100% reimbursed by the National Health Insurance Fund) was extended to all adults with chronic hepatitis C irrespective of fibrosis stage. The most prescribed DAAs have been available in pharmacists since March 2018 and certain DAAs have been available on prescription from all physicians since May 2019, making it easier to treat hepatitis C.

As regards the implementation of a naloxone distribution programme (antidote to opioid overdose) in France, a proprietary medicinal product containing naloxone for nasal use (Nalscue®) obtained a marketing authorisation for use in July 2017. It has been on the market since January 2018 and is only available in CAARUDs, CSAPAs and specialised services. Intramuscular naloxone kits (Prenoxad®) have been available in pharmacists and specialised facilities since June 2019.

Drug consumption rooms, which were previously reserved for users injecting psychoactive substances, have also been available to inhaling or smoking users since July 2019.

T1. National profile and trends

T1.1. Drug-related deaths

The purpose of this section is to

- Provide a commentary on the numbers of drug-induced deaths, i.e. monitoring of fatal overdoses
- Provide a commentary, if information is available, on mortality among drug users, i.e. findings from cohort studies
- Provide contextual information to the numerical data submitted through ST5/ST6 and ST18

T1.1.1. Please comment on the numbers of overdose deaths provided to the EMCDDA in ST5/ST6. Please comment on the numbers of cases and break down by age, gender and intentionality (suggested title: Overdose deaths)

Overdose deaths

In 2016, 463 fatal overdoses were recorded in the National registry of causes of death (National Institute of Health and Medical Research - INSERM's *CépiDC* department). The majority of these deaths (78%) occurred in males. The number of deaths is still underestimated as some overdose deaths are classified as “unknown cause”. In contrast, morphine overdose deaths, particularly occurring among over 50-year-olds, in a palliative care context (choosing a code corresponding to poisoning as the initial cause of death is incorrect in this case) may appear as drug user deaths. In 2015, these deaths account for 21% of deaths assigned a code related to overdose. Emphasis should be placed on fatal overdose among 15-49 year-olds in order to overcome this bias. There were 309 deaths in this age group in 2016.

In 2017, 537 deaths were registered in the specific registers (432 in DRAMES added to the 105 deaths of DTA).

T1.1.2. If information is available, please comment on the substances involved in the overdose cases. If detailed toxicology is reported to the EMCDDA, please comment and elaborate on these findings. If detailed toxicology is not reported, please explain why and comment on available information (suggested title: Toxicology of overdose deaths)

Toxicology of overdose deaths

The DRAMES scheme provides information on the substances implicated (alone or in combination) in deaths related to psychoactive substance abuse (CEIP-A Grenoble 2019). In 2017, opioids were implicated in 78% of the deaths reported in the DRAMES survey. Opioid substitution medications account for 45% of deaths: methadone is involved in 37% of deaths and buprenorphine in 8% of cases. Other opioid drugs (especially morphine) are involved in 13% of deaths, heroin in 25% and cocaine in 26% of fatal drug-related overdoses. The percentage of deaths involving cannabis was 6% (only deaths for which a cardiovascular pathology has been identified), and also 6% for amphetamines and MDMA and 3% for new psychoactive substances (NPS). In 31% of deaths, several substances were involved.

Twelve deaths were directly caused by new psychoactive substances; these involved the following molecules: 25I-NBOMe, carfentanil, U-47700, 4 methylpentedrone (all 4 implicated for the first time in 2017) as well as 3-MMC, 4-MEC, PMMA, ocfentanil, ethylphenidate.

In 2017, two deaths related to ketamine were reported.

In 83% of cases, deaths directly related to drugs identified in DRAMES concerned men. In 2017, the average age of death was 38.3 years old (37.0 years old for women and 38.6 years old for men), down 0.6 years from 2016 after an increase of 4.6 years between 2011 and 2016.

The national health alert system related to the use of psychoactive substances brings together the National health directorate (DGS), *Santé Publique France* (the Public Health Agency), ANSM (the National Agency for Medicines and Health Products Safety), ANSES (the Agency for Food, Environmental and Occupational Health & Safety), OFDT and MILDECA. It aims to organise information sharing between the different stakeholders and bodies concerned, and to improve the management of unusual events related to psychoactive substances, liable to result in health alerts being issued and then managed. In addition, the OFDT compiles the various findings received throughout the year, either by the aforementioned institutions or by other sources (the police, TREND/SINTES network, monitoring network for adverse drug reactions, private analysis laboratories, scientific publications, etc.).

In this context, 7 deaths were reported in 2018 by various sources, including 5 related to NPS use. One death was due to a cathinone, which was consumed intensively in a sexual context (*chemsex*). Three other deaths were related to synthetic opioid use, but only one death was fully analysed, which showed ocfentanil and cocaine in biological samples (both products having a direct impact on the death). The other two deaths also concerned regular cocaine users, who bought powder, without knowing what the name of the substance was that had been given to them, which was found to contain fentanyl or one of its derivatives (clinical signs of an opioid overdose, but without analysis). The last death was an involuntary ingestion of GBL in a nightclub. Furthermore, a teenage death highlighted the misappropriation of air dusters for the computer (mixture of butane and propane) in this group without this use being documented elsewhere.

With regards to synthetic opioids, there were 26 cases of intoxication reported in France between 2015 and 2018, 7 of which were fatal. These figures do not take into account two episodes of grouped cases that occurred in the Auvergne-Rhône-Alpes region between 2016 and 2017, that were documented in a way that was too unclear, which could amount to an additional 4 deaths and 3 non-fatal intoxications. Of these 26 cases, 4 cases concerned carfentanyl (1 death and 3 intoxications) and 9 cases concerned ocfentanil (5 intoxications and 4 deaths, all proven by biological analyses) - some of these cases of ocfentanyl intoxication were outlined by Allibe (Allibe *et al.* 2019). For the remaining cases, the clinical characteristics were not confirmed by toxicological evidence in powders or biological samples.

Specific techniques must be used to find synthetic opioids in biological samples. Indeed, toxicological research using gas chromatography mass spectrometry (GC-MS) or a liquid chromatography coupled with a diode array detector (LC-DAD) may fail to detect these compounds when they are in low concentration in biological fluids (Allibe *et al.* 2019).

T1.1.3. ***Optional.*** *Please comment on the overall and cause specific mortality rates observed through cohort studies among drug users.*
If detailed results from the cohorts are available and reported in ST18, please comment considering age and gender breakdown where appropriate. If detailed findings are available and not reported in ST18 (e.g. reference to published paper without direct access to the raw data) please comment on the available information (suggested title: Mortality cohort studies)

Mortality cohort studies
See T1.1.3 of the 2018 workbook on Harms and harm reduction.

T1.1.4. Trends: Please comment on the possible explanations of short term (5 years) and long term trends in the number of drug-induced deaths among adults, including any relevant information on changes in specific sub-groups. For example, changes in demography, in prevalence and patterns of drug use, in policy and methodology, but also in the data completeness/coverage; case ascertainment, changes in reporting

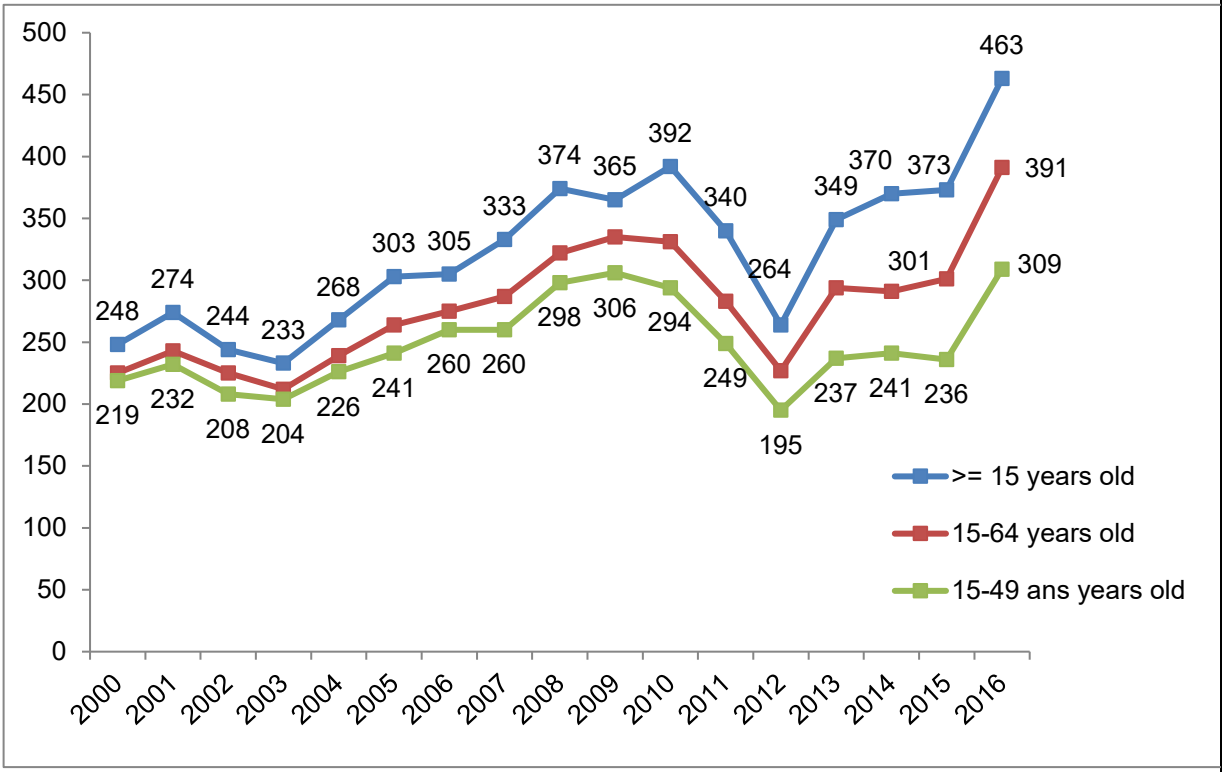
Short term trends

Drug-related deaths

After a period of decrease in 2011 and 2012, data from the mortality register shows an increase in the number of fatal overdoses since 2013 partly due to the rise in "false-positive" cases: morphine overdose deaths in a palliative care or cancer context and deaths of drug users not related to an overdose but to a pathology most often infectious (endocarditis, pneumopathy or sepsis). It has then been followed by stable levels among under 49s in 2014 and 2015 (see figure below). The share of deaths related to these "false positives" has increased in recent years (estimated at 19% in 2012, 27% in 2013, 29% in 2014 and 32% in 2015). In 2016, the number of DRDs increased by 24% compared to 2015 (31% among 15-49 year olds). This increase is only for people under 65 years old.

Changes in the number of drug-related deaths (DRD) in under 50s appear to be strongly linked to the availability and purity of heroin. Similar trends can be observed in the overall number of DRD in terms of deaths directly related to heroin, the quantities of heroin seized (reflecting the availability of the substance) and the heroin potencies in seizures. The changes in the quantities of heroin seized between 2000 and 2015 therefore seem to explain for the most part the changes in the number of drug-related deaths over this period (Brisacier *et al.* 2019).

Overdose deaths due to narcotic and opioid medication use in France (2000-2016)



Source: INSERM-CépiDc, processed by the OFDT
Note: French adaptation of the EMCDDA selection B (F11, F12, F14, F15, F16, F18, F19, X42, X62, Y12).

Toxicology of drug-related deaths

Between 2011 and 2017, opioid substitution medications were the main substances implicated in overdose deaths ahead of heroin. The proportion of deaths related to these two substances is stable in 2017. The rise in the proportions of heroin-related deaths between 2012 and 2015 (15% and 30% of deaths, respectively) should be considered alongside the increase in heroin purity measured in samples seized by police and *Gendarmerie* (from 7% in 2012 to 16% in 2015, then 15% in 2016) (Néfau 2017).

The proportion of deaths related to licit opioids (excluding opioid substitution medications) was stable (13%) in 2017. Morphine remained the most common cause (26 cases), with the number of pholcodine-related deaths increasing sharply (9 cases), as did tramadol-related deaths to a lesser extent (11 cases), while the number of codeine-related deaths (5 cases) and oxycodone-related deaths (2 cases) has decreased.

The proportion of deaths where cocaine was involved (whether hydrochloride or the base form) increased from 9% to 26% of deaths between 2013 and 2017. In 2017, this figure exceeded the number of heroin-related deaths for the first time. From 2011 onwards, reports of deaths involving cannabis (only deaths where a cardiovascular pathology is known or discovered in the autopsy are included) appeared in connection with toxicologists learning about the cardiovascular toxicity of cannabis (heart attack, stroke). The first cases of NPS-related death were reported in 2013, their number (about ten) is stable since 2015.

It is difficult to interpret variations in the number of deaths collected from one year to the next, as the volunteer-based system is not exhaustive and the participation of toxicological experts progresses each year. In 2017, 51 experts from 28 structures covering 70% of the French territory reported cases (CEIP-A Grenoble 2019).

Table: Breakdown of drug-related deaths by substance(s) involved*, alone or in combination, from 2011 to 2017**

	2011		2012		2013		2014		2015		2016		2017	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Opioid substitution medications	160	**57**	187	**60**	153	**54**	134	**55**	140	**41**	188	**46**	195	**45**
- of which methadone	121	**43**	140	**45**	112	**39**	108	**44**	105	**31**	148	**36**	160	**37**
- of which buprenorphine	40	**14**	47	**15**	45	**16**	28	**12**	36	**10**	42	**10**	35	**8**
Other opioid medications (non-OST)	39	**14**	36	**12**	33	**12**	23	**9**	31	**9**	58	**14**	57	**13**
Heroin	54	**19**	47	**15**	57	**20**	62	**26**	103	**30**	106	**26**	109	**25**
Cocaine	30	**11**	36	**12**	25	**9**	33	**14**	44	**13**	75	**18**	112	**26**
Other illegal substances	16	**6**	31	**10**	47	**16**	32	**13**	74	**22**	64	**16**	65	**15**
- of which cannabis	7	**3**	15	**5**	31	**11**	19	**8**	36	**10**	30	**7**	28	**6**
- of which amphetamines and MDMA/ecstasy	9	**3**	15	**5**	14	**5**	9	**4**	27	**8**	22	**5**	27	**6**
- of which NPS					1		5	**2**	15	**4**	14	**3**	12	**3**
Others (psychoactive medicines, etc.)	8	**2**	9	**3**	43	**15**	36	**15**	55	**16**	63	**16**	33	**8**
TOTAL	280		310		285		243		343		406		432	
Number of participating toxicological experts	36		41		32		38		45		48		51	

Source: DRAMES (*Network of the Regional Abuse and Dependence Monitoring Centres* - CEIP-A of Grenoble and ANSM, National Agency for Medicines and Health Products Safety)

* Only deaths directly caused by drug use are mentioned.

** Several substances can be involved in a death when no predominant substance has been determined.
na: not available

Note: The proportion for the "other" category increased since 2013 due to a methodological change (inclusion of cases involving psychoactive medicines in combination).

Long term trends in drug-related deaths

After peaking in the mid-1990s, the number of overdose deaths rapidly declined notably as a result of the development of OST and loss of interest in heroin. The changes in the nomenclature used to state the causes of death on the certificates, implemented in 2000, make it difficult to interpret the changes at the start of the new decade.

T1.1.5. ***Optional****. Please provide any additional information you feel is important to understand drug related deaths within your country (suggested title: Additional information on drug-related deaths)*

Additional information on drug-related deaths

The annual survey on analgesia-poisoning deaths (known as the DTA survey) conducted by the CEIP-A and ANSM collects cases of deaths related to analgesic medication use (CEIP-A Grenoble 2019). A death cannot be listed in both DRAMES and DTA. Deaths occurring in a context of substance abuse and drug addiction are excluded from DTA (and included in DRAMES), and those occurring in the context of suicide are included in DTA (and excluded from the DRAMES survey).

This DTA survey listed 105 analgesia-related deaths (excluding deaths involving salicylic acid and paracetamol) in 2017. The medications in question were tramadol (47% of deaths), morphine (29% of deaths), codeine (18%), oxycodone (17%), and fentanyl (3%). Mean age at the time of death was 49 years, as in 2016 (versus 43 years in 2015), 58% of deaths occurred in men.

The *Société française de toxicologie analytique* (SFTA) (French Analytical Toxicology Society) has updated in 2019 its guidelines for toxicology analyses in deaths involving NPS (SFTA 2018, 2019). These guidelines set out several points, such as the minimum list of NPS to be researched, the biological media to be analysed, any metabolites to be researched and the stability of the analytes.

The new death certificate came into force on 1 January 2018 [Arrêté du 17 juillet 2017 relatif aux deux modèles du certificat de décès]. The instructions for completing the death certificate (on the back of the certificate) state that the "forensic post-mortem examination required" section should be ticked in the event of overdose. The medical section of the death certificate comprises a new insert on the apparent circumstances of death (including "suicide", "ongoing investigations", "unknown"), another insert on the investigation into the cause of death ("yes, medical investigation", "yes, forensic investigation" or "no"); lastly, there are another two inserts for acute death and the site of the triggering event for violent death. The additional medical section to the death certificate, created in April 2017 [Décret n°2017-602 du 21 avril 2017 relatif au certificat de décès], came into force in January 2018 [Arrêté du 17 juillet 2017 relatif aux deux modèles du certificat de décès]. This is used for stating the causes of death when known several days after death, and after the administrative and medical sections of the death certificate have been sent to the competent organisations and institutions. This additional medical section is completed by the physician who carries out the medical or forensic inquiry into the causes of death, and is exclusively submitted in electronic format. Causes of death which are often not stated on the death certificate in the event of a forensic investigation could be determined in the future, and the underestimation of overdose deaths could then decrease.

T1.2. Drug related acute emergencies

The purpose of this section is to provide a commentary on the numbers of drug-related acute emergencies

T1.2.1. Is information on drug-related acute emergencies available in your country? If yes, please complete section T6.1 (Sources and methodology) and provide in T6.1 the definition of drug-related acute emergencies used and, if available, an overview of the monitoring system in place (suggested title: Drug-related acute emergencies)

Drug-related acute emergencies

See T1.2.1 of the 2018 workbook on Harms and harm reduction.

T1.2.2. If information is available, please provide a commentary on the numbers of drug-related acute emergencies by main illicit substances, e.g. cannabis, heroin/ other opioids, cocaine, amphetamine type stimulants, new psychoactive substances. Please feel free to add tables in this section (as most countries already do). This might facilitate the reading.
Where appropriate please provide links to the original reports and studies (suggested title: Toxicology of drug-related acute emergencies)

Toxicology of drug-related acute emergencies

In 2015, the Oscour® network (coordinated by *Santé publique France*), which covers 86% of emergency room (ER) admissions in France, recorded 13,161 drug use-related ER admissions, including 9,908 as the main diagnosis, i.e. 1.0‰ of ER admissions for all causes combined. On the scale of the French population, the rate of drug use-related ER admissions is 23 per 100,000 inhabitants (after adjustment taking the coverage rate into account). 73% of individuals visiting emergency rooms for this reason were male. Mean age was 34 years, with men being slightly younger than women (33 years vs. 36 years). More than a quarter of these presentations were related to cannabis use (27%), 23% were related to opioid use, cocaine was implicated in 7% of cases, other stimulants (MDMA/ecstasy, amphetamines) in 3% of cases, hallucinogens (hallucinogenic mushrooms, LSD) in 4% of cases and, lastly, multiple or unspecified substances were responsible in 36% of cases. Further to the emergency presentation, 39% of individuals were admitted to hospital, and 61% returned home(Brisacier 2019a).

The Paris sentinel site (emergency room at the *Lariboisière* hospital) taking part in the Euro-Den project listed 454 hospital emergency presentations due to acute drug intoxication between October 2013 and September 2014.

The most frequently reported drugs were cannabis (21%), cocaine (18%), crack (9%), diazepam (9%) and bromazepam (7%). Only one substance was involved in 53% of cases, two in 29% of cases and three or more in 18% of cases. Combined alcohol use was observed in 45% of cases. Median age was 34 years, and 60% were male (Euro-DEN 2015). The Paris site reported 286 presentations between October 2014 and September 2015 (Euro-DEN Research Group and EMCDDA 2016).

T1.2.3. Trends: Please comment on the possible explanations of short term (5 years) and long term trends in the number and nature of drug-induced emergencies, including any relevant information on changes in specific sub-groups. For example, changes in demography, in prevalence and patterns of drug use, in policy and methodology.

See T1.2.3 of the 2018 workbook on Harms and harm reduction.

T1.2.4. ***Optional****. Please provide a commentary on any additional information you feel is important to understand drug-related acute emergencies data within your country (suggested title: Additional information on drug-related acute emergencies)*

T1.3. Drug related infectious diseases

The purpose of this section is to

- Provide a commentary on the prevalence, notifications and outbreaks of the main drug-related infectious diseases among drug users, i.e. HIV, HBV and HCV infections in your country
- Provide contextual information to the numerical data submitted through ST9 including prevalence and behavioural data (e.g. sharing syringes)
- Provide a commentary, if information is available, on the prevalence/outbreaks of other drug related infectious diseases, e.g. STIs, TB, bacterial infections, hepatitis A

T1.3.1. Please comment on the prevalence among drug users and on notifications of the main drug related infectious diseases (HIV, HBV, HCV) provided to the EMCDDA (suggested title: Main drug-related infectious diseases among drug users – HIV, HBV, HCV)

Main drug-related infectious diseases among drug users – HIV, HBV, HCV

Data based on biological samples

See T1.3.1 of the 2018 workbook on Harms and harm reduction.

Reported data

The ENa-CAARUD survey, which was conducted for the fifth time in 2015, questioned 3,129 users seen over the course of a given week in CAARUDs (harm reduction facilities). In 2015, the majority of drug users reported to have carried out a screening test on at least one occasion (89.7% for HIV -stable compared to 2012- and 83.2% for HCV - on the decline compared to 2012). Among drug users having injected at least once in their lives and having carried out a test, 4,6 % declared to be HIV seropositive and 34.4 % HCV seropositive in 2015, a stable figure compared to 2012 (Lermenier-Jeannet et al. 2017).
These reported data are likely to underestimate these seroprevalences, especially for HCV.

In CSAPAs (specialised drug treatment centres), the reported prevalence (among lifetime injecting drug user) corresponds to 6.9% for HIV and 44.3% for HCV, according to the RECAP system in 2017 (Pôle Indicateurs 2018).

Trends

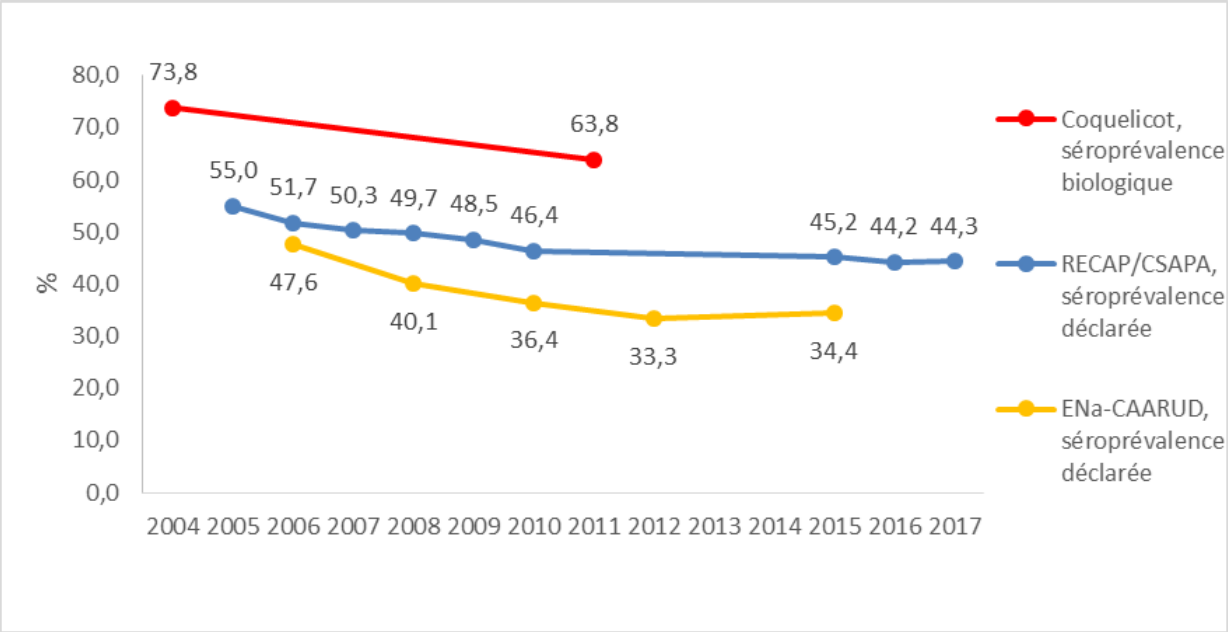
Prevalence and incidence of infections

In 2011, the biological seroprevalence of HCV declined compared to 2004 (63.8% versus 73.8%) while remaining stable for HIV (13.3% versus 11.3%) among drug users having injected at least once in their lives (DREES 2015).

These trends are identical to the changes in the reported prevalence of HCV and HIV among injecting drug users originating from the RECAP scheme (from 49.7 % in 2008 to 46.4 % in 2010 for HCV, stable at nearly 8% for HIV) and the ENa-CAARUD survey (from 40.1% in 2008 to 33.3% in 2012 for HCV, stable at 6.2% in 2012 *versus* 7.7% in 2008 for HIV) (Cadet-Taïrou et al. 2015; Vaux et al. 2017). The reported prevalence remained stable, both for HIV and HCV, between 2012 and 2015 in CAARUDs and between 2012 and 2017 in CSAPAs. This stability highlights the end of the declining prevalence of HCV among IDU observed since the beginning of the 2000s (Lermenier-Jeannet *et al.* 2017; Pôle Indicateurs 2018; Vaux *et al.* 2017).

The incidence of HCV among drug users was estimated based on a mathematical model linking prevalence and incidence. The incidence of HCV fell from 7.9/100 person-years (95% CI 6.4-9.4) in 2004 to 4.4/100 person-years in 2011 (95% CI 3.3-5.9). Among active IDUs, this incidence increases two-fold, and fell from 15.4/100 person-years in 2004 (95% CI 11.9-19.3) to 11.2/100 person-years in 2011 (95% CI 9.0-19.0) (Léon et al. 2017). The number of new chronic infections per year is estimated at 4,400 among IDUs, representing 80% of all new cases in France (Brouard et al. 2019).

Figure. Trends in HCV seroprevalence among injecting drug users



Sources:
ANRS-Coquelicot/InVS: *biological prevalence, lifetime IDU*
RECAP/OFDT: *reported prevalence, lifetime IDU among CSAPA clients*
ENa-CAARUD/OFDT: *reported prevalence, lifetime IDU among* CAARUD clients

UDI: injecting drug use
CAARUD: harm reduction facilities/low-threshold structures treating drug users
CSAPA: specialised drug treatment centres for drug users

T1.3.2. ***Optional.*** *Please comment on notification data (e.g. notification of new HIV and AIDS cases among drug users). Short descriptions of outbreaks/clusters, specific surveys or other relevant data can be reported here (suggested title: Notifications of drug-related infectious diseases)*

Notifications of drug-related infectious diseases

In 2017, 127 injecting drug users (IDU) were newly diagnosed as being HIV seropositive i.e. 2.0% of all new diagnoses. The data correction method was adapted following the transition from paper to online reporting, resulting in a higher estimate of the number of HIV-positive discoveries than has ever been previously produced (See section T5.1 on sources at the end of this document). In 2017-2018, the proportion of diagnoses at an advanced stage (CD 4 > 200 or AIDS) was high among IDU (46% compared to 28% of all discoveries). Almost two thirds (64%) of them reported that they had never been tested before, with only 27% of IDU reporting that they had been tested within the last year. More than two thirds of IDU who discovered they tested positive for HIV (71%) were born abroad. The share of people also infected with HCV was 75% and the proportion of people who were also affected by a bacterial sexually transmitted infection was 15%.

The share of IDU with AIDS was 3.7%. Only half of them had received antiretroviral drugs before they were diagnosed with AIDS *(*compared to 80% of all newly diagnosed AIDS cases). Finally, IDU account for 22% of all AIDS deaths (Lot *et al.* 2019; Santé publique France 2018).

No compulsory notification systems for diagnoses of chronic hepatitis C exist in France.

Only a quarter of acute hepatitis B cases (for which compulsory declaration was introduced in 2003) were declared in 2013. The number of acute hepatitis B cases diagnosed was estimated at 291, taking under-reporting into account, i.e. an estimated incidence of 0.44 (95% CI: [0.39-0.50] per 100,000 inhabitants in 2013. Among the cases declared, 5% of persons reported drug use in the 6 months prior to diagnosis (Brouard *et al.* 2016).

Trends

The annual number of new seropositive diagnoses among IDUs decreased by 40% between 2010 and 2017.

The share of IDUs among new AIDS cases fell by almost half between 2010 and 2017. Following a dramatic decline in the number of new AIDS cases among IVDU between 1995 and 1997, notably related to the introduction of tritherapy delaying entry into the symptomatic phase of infection, the rate of this decrease was slower but almost consistent until 2009 and even weaker until 2016 (OFDT 2018). This downward trend is also related to the reduction in the number of new cases of HIV infection related to injecting drug users.

The introduction of tritherapy in 1996 led to a four-fold reduction in the number of AIDS deaths among IDUs between 1994 and 1997. The number of deaths then continued to fall but at a slower rate, alongside a marked decrease in the prevalence of HIV among IDUs. However, the proportion of IDU among all people who died of AIDS remains high, fluctuating between 16.8% and 31.2% between 2010 and 2017 (Santé publique France, unpublished data).

These trends can be explained by different factors: the impact of the different public health measures taken in France (and harm reduction measures in particular), greater accessibility to treatment, greater access to screening, changes in drug use practices and a drop in injection in particular.

T1.3.3. ***Optional****. Please comment on any information on prevalence of HIV, HBV, HCV among drug users from other sources. Where appropriate please provide links to the original studies (suggested title: Prevalence data of drug-related infectious diseases outside the routine monitoring)*

See T1.3.3 of the 2018 workbook on Harms and harm reduction**.**

T1.3.4. ***Optional.*** *Please comment on available behavioural data (e.g. sharing, slamming…). Where appropriate please provide links to the original studies (suggested title: Drug-related infectious diseases - behavioural data)*

See T1.3.4 of the 2018 workbook on Harms and harm reduction.

T1.3.5. ***Optional****. Please provide, if information is available, a comment on the prevalence of other infectious diseases e.g. STIs, TB among drug users. Where appropriate please provide links to the original studies (suggested title: Other drug-related infectious diseases)*

T1.3.6. ***Optional****. Please provide any additional information you feel is important to understand patterns and trends in drug related infectious diseases within your country (suggested title: Additional information on drug-related infectious diseases)*

T1.4. Other drug-related health harms

The purpose of this section is to provide information on any other relevant drug related health harms.

T1.4.1. ***Optional****. Please provide additional information on other drug-related health harms including co-morbidity (suggested title: Other drug-related health harms)*

See T1.4.1 of the 2018 workbook on Harms and harm reduction.

T1.5. Harm reduction interventions

The purpose of this section is to

- Provide an overview of how harm reduction is addressed in your national drug strategy or other relevant drug policy document
- Describe the organisation and structure of harm reduction services in your country
- Comment on the harm reduction provision (activities/programmes currently implemented)
- Provide contextual information useful to understand the data submitted through SQ23/ST10.

T1.5.1. Please summarise the main harm reduction-related objectives of your national drug strategy or other relevant policy documents (cross-reference with the Policy workbook). Include public health policies, strategies or guidelines relevant to the prevention and control of health-related harms, such as infectious diseases among PWID (e.g. HIV and hepatitis action plans or national strategies) and national strategies regarding the prevention of drug-related deaths. Please specify the defined actions and targets and provide references to these documents in section T 5.1. Trends: Please comment on current trends regarding these policies (suggested title: Drug policy and main harm reduction objectives)

Drug policy and main harm reduction objectives

The harm reduction policy towards drug users falls under the responsibility of the state (article L.3411-7 of the Public Health Code modified by article 41 of the law on health system reform of 26 January 2016 [Loi n°2016-41 du 26 janvier 2016 de modernisation de notre système de santé]) It aims to prevent health-related, psychological and social harm, the transmission of infections and overdose deaths related to the use of psychoactive or narcotic substances. It also applies to inmates (article L.3411-8 of the Public Health Code). The law of 9 August 2004 [Loi n°2004-806 relative à la politique de santé publique], which created CAARUDs (Support Centres for the Reduction of Drug-related Harms), stipulates that along with numerous other schemes and measures, these low-threshold structures should be used to further enforce the harm reduction policy (article L.3411-9 of the Public Health Code).

Since May 1987, the unrestricted sale of syringes is authorised in retail pharmacies, in-house pharmacies located within health establishments and establishments dealing exclusively in medical-surgical and dental equipment or that have a specialised department for such sales. Since March 1995, syringes may be issued free of charge by any not-for-profit association carrying out AIDS prevention or harm reduction measures among drug users and meeting the requirements described in a legislative order issued by the Ministry of Health (article D.3121-27 of the Public Health Code). The dispensing of syringes and needles to minors is only authorised upon presentation of a prescription (art. D.3121-28 of the Public Health Code). However, neither pharmacies nor associations are legally required to ask users for proof of their identity or age since.

A national harm reduction standard for drug users was prepared (art. D.3121-33 of the Public Health Code) and approved via the decree of 14 April 2005 [Décret n°2005-347 approuvant le référentiel national des actions de réduction des risques en direction des usagers de drogue et complétant le code de la santé publique] and reasserted in the law on health system reform of 26 January 2016 (article 41). This decree stipulates that all participants, health professionals, social workers or members of associations, in addition to any persons to whom these activities are addressed, must be protected from accusations concerning the use or the incitement to use drugs during their work.

In 2014, a recommendation report on the treatment of people infected with hepatitis B or C was drafted under the supervision of the National AIDS and viral hepatitis Research Agency (ANRS) and the French Association for the Study of the Liver (AFEF) at the request of the Ministry of Social Affairs and Health (Dhumeaux *et al.* 2014). This report was updated in 2016 (Dhumeaux *et al.* 2016). This report suggests re-initiating hepatitis B and C prevention, to incorporate an organised approach to the phases of patient treatment and to support efforts towards equal access to screening and care.

Prevention policy priorities include a significant measure: elimination of hepatitis C by 2025 in France (the WHO worldwide target is 2030). In order to achieve this objective, 3 key measures are being implemented: greater access to treatment for hepatitis C via new prescribers by encouraging city-hospital networks; increasing local screening via rapid diagnostic tests (RDT) as part of a combined approach for HIV, HCV and HBV, and improving prevention via innovative outreach actions aimed at priority populations far removed from the health system (Direction générale de la santé 2018).

During 2017, reimbursement of direct-acting antivirals (DAA) (100% reimbursed by the National Health Insurance Fund) was extended to all adults with chronic hepatitis C irrespective of fibrosis stage [Instruction n°2017-246 du 3 août 2017]. Individuals at high risk of virus transmission (drug users who share equipment, inmates, women planning a pregnancy) already benefited from a 100% coverage of direct-acting antivirals (DAA) by the Health Insurance since August 2016 [Arrêté du 10 juin 2016 and Instruction n°2016-246 du 28 juillet 2016 relative à l'organisation de la prise en charge de l'hépatite C par les nouveaux anti-viraux d'action directe (NAAD)]. Previously, only individuals with severe chronic hepatitis (fibrosis score ≥2) and/or co-infected with HIV were covered by the National Health Insurance Fund for DAA.

Physicians have been able to prescribe two DAAs (Marivet®, Epclusa®) since May 2019. This measure is accompanied by the provision of a memo sheet from the French National Authority for Health on the simplified management of hepatitis C in adults (HAS 2019a, b). For the other DAAs, prescription remains reserved for specialists in hepatogastroenterology, internal medicine or infectious diseases. A multidisciplinary meeting is no longer automatically required before initiating treatment with DAA. However, it is still recommended in complex cases [Instruction n°2017-246 du 3 août 2017]. Since March 2018, several DAA are available in community pharmacies (in 2019, Marivet®, Epclusa®, Sovaldi®, Harvoni®, Vosevi®, Zepatier®), while the other treatments are only available in hospital pharmacies. The price of a cure (from 8 to 12 weeks depending on the combination of DAA) has decreased in 2018 and amounts to nearly €25,000 including VAT for the least expensive ones. Screening still needs to be improved for individuals never having been screened (30% of infected individuals have no risk factors) and given new impetus and stepped up for individuals at risk (at-risk behaviour – injecting drug users, slamming -, migrants, inmates, psychiatric patients) (Salomon 2018).

The French Association for the Study of the Liver (AFEF) issued guidelines in March 2018 for the elimination of hepatitis C virus infection in France, based on two main approaches: universal treatment and universal screening (AFEF 2018). It proposes a treatment algorithm with the implementation of a simplified treatment pathway enabling local management. A working group bringing together the AFEF and the French Federation of Addiction Care

proposes to create a treatment plan that treats both drug-dependent clients' livers and digestive systems (Delile *et al.* 2018a; Groupe de travail FFA et AFEF 2019).

A study on cost effectiveness comparing five strategies targeting people at-risk, either certain age groups or the general population, showed that universal testing was the most effective strategy in France (Deuffic-Burban *et al.* 2018) for HCV.

A methodological guide aiming to increase access to screening and treatment for viral hepatitis intended for all socio-educational, paramedical and medical professionals in the specialised addiction medicine structures (CSAPA, CAARUD, ELSA[1], hospital addiction medicine departments, etc.) was drawn up by the Research Group on Social Vulnerability and presented during the National Viral Hepatitis Action Day (Hoareau and Reynaud-Maurupt 2018). Raising awareness with regard to screening should be a major line of action within the structures and outside their walls, as part of an outreach approach. Hence, drug users attending CSAPAs or CAARUDs should be routinely invited for screening (with combined HCV-HBV-HIV RDT, blotters and Fibroscan®) while leveraging advanced hepatology clinics, following the example of the treatment pathway in the Ile-de-France region.

A white paper on access to care among populations vulnerable to hepatitis C summarises and expands the previous reports and guides professionals towards more integrated, facilitated management, more targeted to particularly affected/vulnerable populations. It helps professionals in all fields to coordinate their practices, to achieve the objective of eradicating the epidemic in France by 2025 (Delile *et al.* 2018a; Delile *et al.* 2018b).

The National Sexual Health Strategy (2017-2030 agenda) (Ministère des affaires sociales et de la santé 2017), which is in keeping with the objectives of the National Health Strategy (particularly with its objective for "Promoting sexual health and sex education"), proposes a global approach to improving sexual and reproductive health which notably aims to eradicate the AIDS epidemic by 2030 and to reach the goal of "95-95-95" by 2020: such that 95% of people living with HIV know their status, 95% of people who know their seropositive status have access to treatment and 95% of people on treatment have suppressed viral loads. Action no. 4 endeavours to meet the specific needs of the most vulnerable populations, including drug users. The roadmap of the National Sexual Health Strategy (2018-2020) recommends organising, annually and at local level, specific screening campaigns for HIV, viral hepatitis and other STIs, including "outreach" programmes aimed at key populations including injecting drug users (action no. 4) (Ministère des solidarités et de la santé 2018) in compliance with the guidelines issued by the French National Authority for Health (HAS 2017).

In 2019, the Court of Accounts, referred by the Chairman of the Senate Social Affairs Committee for an enquiry into HIV prevention and care, found that France did not have the means to achieve the ambitious objectives it had set itself to eradicate new cases by 2030. Increasing the availability of HIV testing, increasing the spread of pre-exposure and post-exposure prophylaxis, improving epidemiological tools and better regulating the expenditure on antiretroviral drugs are among the ten guidelines made by the Court of Accounts (Cour des comptes 2019).

The 2018-2022 national action plan on addictions (MILDECA 2018) aims to improve harm reduction resources by:

- adapting the reference framework for harm reduction workers
- adapting resources to needs
- continuing to trial drug consumption rooms
- preventing overdose

(See the Drug Policy workbook for the main lines of this plan)

[1] hospital-based addiction liaison and treatment team

The Ministry of Health and Solidarity (Ministère des solidarités et de la santé 2019) has developed a roadmap for preventing and responding to opioid overdoses, with five objectives:

1. Improving professional practices
2. Ensuring ready-to-use naloxone is widely spread
3. Involving users and their friends and family
4. Networking everyone involved on a territorial level and promoting collaborative local action
5. Improving the vigilance, alert and response system

Implementing this plan over the 2019-2022 period requires improved coordination between all the stakeholders involved (primary health professionals, addictologists, algologists, pharmacists, medical and social professionals, clients and user associations), across different territories, meeting needs as closely as possible.

A multi-year action plan for 2019-2021 for coordinated mobilisation on the crack problem in Paris was adopted in 2019. Divided into 33 actions, it proposes:

- to support users to reduce risks and harm and promote treatment pathways;
- to offer accommodation, shelter, create rest areas and dedicated accommodation and residential care units, in order to gradually get people off the street;
- to intervene in public places, reach out to users and meet residents' needs in order to improve public order and fight against trafficking;
- to improve knowledge on the subject.

(See also section T3 of the Drug Policy workbook)

T1.5.2. Please describe the structure of harm reduction service organisation in your country, including funding sources. Describe the geographical coverage. Comment on its relationship to the treatment service provision system and the extent to which these are integrated or operate separately. Where possible, please refer to the EMCDDA drug treatment system map (see Treatment workbook) to identify the range of treatment providers that are also delivering harm reduction services. Trends: Please comment on trends regarding harm reduction service organisation (suggested title: Organisation and funding of Harm reduction services)

Organisation of harm reduction services

In order to guarantee a widespread access for drug users to harm reduction measures, the health authorities have promoted local services based primarily on pharmacies, primary care and dispensing machines. The medico-social system (CAARUDs and CSAPAs) supplements and develops this local access offer. The following indicators are useful to assess the actual coverage of the systems in place.

Level of involvement and location of pharmacy professionals

Nearly half (48%) of the retail pharmacies surveyed in 2010 by the ANSM stated having provided information on the prevention of infectious diseases to drug users, and 40% confirmed having syringe retrieval systems (Lapeyre-Mestre and Boeuf-Cazou 2011). Of the pharmacies surveyed, 79% see at least one patient per month being treated with opioid substitution treatment, 78% dispense *Stéribox*® units[2], but only 16% dispense individual syringes, and even fewer (1.2%) dispense *Stérifilt*®[3] and *Stéricup*®[4] units. The addiction prevention network (RESPADD) produced the 2018 directory of pharmacy Syringe Exchange

[2] Prevention kits intended to limit the risks of transmitting infectious diseases among injecting drug users.
[3] A filter that removes impurities from a drug preparation for injection, thereby limiting the risk of the vascular and infectious complications related to injection (e.g., abscesses, oedema, phlebitis). For single-use only, this sterile filter aims to prevent injection equipment reuse or sharing.
[4] A sterile aluminium recipient that diminishes the risks of infection due to the reuse and sharing of injection preparation equipment.

Programmes (SEP). This directory offers an extensive list of all the French SEP categorised by region and department. For each of them, it gives the name and details of the facility coordinating the programme as well as the number of pharmacists involved: 1,717 across the country (RESPADD 2018).

Level of professional involvement in primary care

Health care delivery, concerning opioid substitution treatment (OST), is largely based on primary care practitioners (see Treatment workbook).

National coverage of medical-social harm reduction systems

In 2015, medico-social harm reduction facilities (CAARUD and CSAPA) covered the majority of the French territory: 8 departments (out of a total of 101) do not have a CAARUD, and all departments have CSAPA. As regards the geographical distribution at national level, these facilities are highly concentrated in large towns. Hence, Paris, Lille and Marseille have the highest concentration of sites (respectively 9, 6 and 5 CAARUD). Two other urban centres, Bayonne and Nîmes, have 3 structures and ten or so other urban areas have 2 CAARUDs (Avignon, Bordeaux, Lyon, Metz, Montpellier, Mulhouse, Nancy, Nice, Rouen and Toulouse). The remaining towns concerned (approximately a hundred) have only one CAARUD.

CAARUD harm reduction activities

In 2016, 147 CAARUDs were registered in France, including six located in French overseas departments. A new structure started its activity in 2016 in Annecy in Haute-Savoie (south-east of France). The CAARUDs are predominantly funded by the National Health Insurance Fund, in compliance with the French Social Action and Family Code (art. L. 314-3-3). Subsidies paid to structures located in mainland France in 2016 represent approximately €48.6 million and a little over a million euros for structures located in French overseas departments. These receive operating subsidies of €1,000 on average per 1,000 inhabitants aged 20 to 74 in mainland France. Structures located in French overseas departments receive nearly €700 on average per 1,000 inhabitants. Relative to CAARUD new outpatient admissions, this budget only represents slightly over €350 per client taking part in the scheme compared to approximately €700 on average for structures in mainland France.

Nearly all CAARUDs see their clients in permanent premises or in a mobile unit. CAARUDs most frequently operate from permanent premises (75%), and half of these structures have mixed counselling facilities (simultaneously operating from both types of facilities). In 2016, the annual CAARUD new outpatient admissions were estimated at just over 79,000 individuals, and 5,500 of them were seen in structures located in the overseas territories. In terms of intervention, the number of new outpatient admissions to facilities based in a fixed location is estimated to be almost 46,000 people. While the figure for facilities based on a bus or mobile unit is 13,000 people. The proportion of new users visiting the facilities in 2016 represents 32% in permanent premises and 30% in mobile units, i.e. nearly 15,000 and 4,000 individuals, respectively. Female clients are in the minority, with women accounting for 18% of visitors to CAARUD premises, and 21% of clients followed up by mobile units, i.e. 8,000 and 2,800 women, respectively.

Their main actions include creating links with the most vulnerable drug users, access to essential services, health care and social rights. Hence, in 2016, the most common actions involved maintaining social links or counselling (40%), harm reduction measures related to drug use and sexuality (22% of actions carried out) and responding to the most basic needs (basic hygiene) corresponding to 18% of total actions. Actions relating to care and access to services are observed to a relatively lesser extent (6% and 5%, respectively). Access to

screening for infectious diseases and vaccinations, and access to housing and training are observed to a very marginal extent in these interventions (between 1% and 2%). Despite the national plan against hepatitis B and C encouraging drug users to be tested and vaccinated, only around 30 people were tested for hepatitis B and C for free in HR facilities. However, the majority of CAARUDs (more than 70% for hepatitis C and 60% for hepatitis B) referred users to other facilities for free hepatitis testing. Access to vaccination for HBV seems very limited (this only appears to be offered by a small minority of facilities). This situation remains almost identical to that observed in 2015.

The intervention processes are fairly similar. In 2016, practically all CAARUDs offered users orientation services and support projects (97% and 96%, respectively). As regards practical intervention procedures, individual interviews have been shown by far to be the most common practice (99%) and nearly nine out of ten CAARUDs (89%) proposed workshops (photography, theatre, journaling). Lastly, slightly over a third of structures organised self-help and self-support groups (40%) (Díaz Gómez 2018).

Although harm reduction measures constitute one of their missions, the role of the CSAPA cannot be quantified due to the lack of data.

T1.5.3. Please comment on the types of harm reduction services available in your country provided through low-threshold agencies and drug treatment facilities (suggested title: Provision of harm reduction services)

a) Describe how **infectious diseases testing** is organised and performed in your country, incl. for which infections drug users are screened, **and if testing is routinely available at drugs facilities**;
b) Describe how **syringe distribution** is organised in your country (reference to ST 10 data),
c) Which equipment and drug use paraphernalia (beyond syringes/needles) are provided (indicate your reply by "x" in relevant box- one per line);
If available, address:
d) Take-home naloxone programmes and emergency response training (settings, target groups);
e) Supervised drug consumption facilities;
f) Post-release / transition management from prison to community, provided by drugs facilities;
g) Vaccination, e.g. hepatitis B vaccination campaigns targeted at PWID;
h) Infectious diseases treatment and care: e.g. describe referral pathways or care partnerships;
i) Sexual health counselling & advice, *condom distribution;*
j) Optional. Interventions to prevent initiation of injecting; to change route of administration of drugs; mental health assessments.

The prevention measures used in France are of various types.

a) Infectious diseases testing

The testing system is particularly based on 317 CeGIDD (free information, screening and diagnosis centres on human immunodeficiency virus infection, viral hepatitis and sexually transmitted infections) [Décret n° 2015-796 du 1er juillet 2015 relatif aux centres gratuits d'information, de dépistage et de diagnostic des infections par les virus de l'immunodéficience humaine et des hépatites virales et des infections sexuellement transmissibles], in 2016 (167 main sites and 150 branches). These centres, which were created in 2016, are the result of the anonymous free screening centres (CDAG) merging with centres for providing information, screening and diagnosis on sexually transmitted diseases (CIDDIST). The aim of creating CeGIDDs is to make it easier for users to access services and to improve the quality of the prevention and screening services provided. The principle of free access remains, but the care may be anonymous or not; the user can choose when they start the programme. An initial assessment of CeGIDD activity, which carried out 739,000 consultations in 2016, indicated a development of a more global approach to sexual health and a shift in focus to reaching the most exposed groups, particularly by taking more action outside the centres themselves by testing people (Lailler *et al.* 2018). Of the 372,000 people who attended the centres in 2016, 13,300 were drug users.

Users can visit CeGIDDs, and may be referred there or accompanied by CAARUD staff members. There are also local harm reduction measures or treatment centres that organise the on-site collection of samples for screening purposes. CSAPAs also provide screening free of charge. Finally, access to screening is also possible via the traditional care system. However, whereas the cost of screening for HIV and HCV infections is 100% covered by the French National Health Insurance Fund (*Assurance maladie*), the screening for chronic HBV markers is only reimbursed at a rate of 65%.

At the request of the National health directorate (DGS), in May 2014 the National authority for health (HAS) issued recommendations on the utility of rapid diagnostic tests (RDTs) for HCV in the hepatitis C screening strategy (HAS 2014). Given their performance and advantages (simple to use, quick results, acceptable, no initial venous sample needed, can be used in a remote setting), the HAS positions RDTs as an additional screening tool that could be of interest for drug users in particular. HCV RDTs could be used in CSAPAs and CAARUDs by health care or non-medical professionals provided that the latter group has first followed training (for both HIV and HCV). In the event of a positive result, systematic confirmation is required using immunoenzymatic testing (third generation Elisa) on venous samples. However, it is imperative to firstly put in place a treatment network downstream to facilitate access to patients who have been screened positive and to coordinate all stakeholders and health professionals involved in the hepatitis C treatment process. Reiterating the recommendations issued by the HAS, Article 39 of the French law on health system reform of 26 January 2016 extends the practice of RDT from health professionals only to personnel in community or prevention facilities having received appropriate training [Arrêté du 1er août 2016 fixant les conditions de réalisation des tests rapides d'orientation diagnostique de l'infection par les virus de l'immunodéficience humaine (VIH 1 et 2) et de l'infection par le virus de l'hépatite C (VHC) en milieu médico-social ou associatif]. Rapid diagnostic tests can thus be performed within CAARUDs and CSAPAs, provided that these facilities received an authorisation from the Regional Health Agency. RDTs can be performed by nurses, midwives, doctors and pharmacists [Arrêté du 1er août 2016 déterminant la liste des tests, recueils et traitements de signaux biologiques qui ne constituent pas un examen de biologie médicale, les catégories de personnes pouvant les réaliser et les conditions de réalisation de certains de ces tests, recueils et traitements de signaux biologiques]. Lastly, screening via RDT may be carried out on minors.

The HAS recommends the use of RDT for HBV (HBs Ag) as an additional screening tool to conventional laboratory screening, once it can be shown to be more suitable for reaching non-screened or inadequately screened at-risk populations, such as individuals frequenting the CAARUD and CSAPA (HAS 2016).

Self-screening tests for HIV-infection screenings are available in pharmacies since September 2015. These tests do not replace other screening devices, they complement the measures available to meet specific needs.

Some CAARUD perform liver test exams by Fibroscan® (a non-invasive machine that can instantly detect liver fibrosis and assess its degree of advancement) to assess the level of hepatic fibrosis and, if necessary, enable drug users to be referred for more extensive testing. Some CAARUD also have Cepheid's GenExpert device which can measure the HCV viral level in less than 2 hours.

b) Organisation of syringe distribution

Since 1987, syringes have been on unrestricted sale in community pharmacies (without a prescription). Injection kits (*Stéribox*®) are also sold in pharmacies (since 1994) and distributed via automatic distribution machines (since 1995) to allow access to syringes. Syringes and injection kits are also distributed by CAARUDs (since 2006) and CSAPAs (since 2008). The supply of equipment also extends to injection equipment distributed as part of the postal harm reduction programme, launched in 2011.

The supply of injection materials is based on the following four distribution methods:

- Distribution by the CAARUDs, CSAPAs and partner community pharmacies
- Sales of injection kits in pharmacies in *Stéribox*® form and sales of single sterile syringes
- Distribution of syringes via automatic distribution machines (outside the CAARUD/CSAPA network)
- Postal needle and syringe exchange programme

In total, approximately 11.97 million syringes are estimated to have been distributed or sold to drug users in France in 2016, for all schemes combined.

b.1) Distribution of sterile single-use prevention material by the CAARUD and CSAPA

The provision of prevention resources and the collection of soiled equipment are perceived as the key mission of harm reduction facilities. The CAARUD play a key role in distributing injection equipment and sterile prevention material (see table below). In 2016, CAARUDs contributed 7.36 million syringes to harm reduction resources.

*Table: Distribution of sterile prevention material by the CAARUD network in 2016**

Injection equipment	
Single syringes	4,919,516
Syringes in kits: automatic distribution machines	420,292
Syringes in kits: teams	955,574
Syringes in kits: pharmacy network	1,061,316
Total number of syringes distributed	*7,356,698*
Needles	396,225
Sterile containers	2,500,971
Sterile filters	1,543,423
Water (5-ml vials)	2,803,283
Alcohol pads	2,867,332
Snorting equipment	
Small paper pads	627,940
Normal saline solution	181,143
Other snorting equipment	31,121
Crack inhalation equipment	
Measures	126,268
Tips	73,169
Healing cream	240,634
Inhalation kits	28,604
STI prevention material	
Male condoms	732,000
Female condoms	28,762
Lubricant gel	284,684
Other prevention materials	
Alcohol breath tests	42.980
Ear plugs	63.454
Brochures, flyers	171,195

Source: CAARUDs 2016 activity reports (DGS – processed by the OFDT)

** This table shows the harm reduction materials dispensed by the teams at the facilities and via automatic distribution machines in the CAARUD network, but also by partner pharmacies. It does not list materials supplied outside of the CAARUD scheme.*

Since 2008 [Circulaire DGS/MC2 n°2008-79 du 28 février 2008 relative à la mise en place des CSAPA], CSAPAs must implement risk reduction measures for the public they take care of. In 2016, the CSAPA network distributed overall approximately 433,000 syringes.

b.2) Sale of syringes in pharmacies

Sales of syringes in pharmacies in *Stéribox*® form represent the second most important distribution method for sterile injection materials. As data transfer was suspended between 2012 and 2015, information is only available on *Stéribox*® sales from 2016 onwards. Since data transfer resumed, sales were seen to fall by a third in 5 years. Hence, the number of syringes sold in community pharmacies in *Stéribox*® form decreased from 4.45 million in 2011 to 3.35 million in 2016. Since then, this downward trend has not diminished with 3.11 million syringes sold in 2018.

b.3) Distribution of syringes via automatic distribution machines (outside of the CAARUD/CSAPA network)

Organisations specialising in addiction medicine are not alone in distributing prevention material via automatic distribution machines. Other structures such as non-CAARUD / CSAPA associations and communities also distribute prevention equipment via dispensing machines and provide drug users with prevention kits[5] such as the *Stéribox*® kit or *Kit+*. In 2016, about 560,000 syringes were distributed via automatic distribution machines outside the CAARUD/CSAPA network (Duplessy 2015). The distribution of prevention material via this method aims to guarantee anonymity and 24-hour access to resources.

The total number of automatic distribution machines (CAARUD/CSAPA network and other operators) reaches almost 300 operational automatic distribution machines for prevention kits in approximately half of French administrative departments. However, the system is fragile since one quarter of the dispensers and one third of the exchange devices were in a bad state of repair (2016 directory of automatic distribution machines, Safe association data).

b.4) Postal syringe exchange programme

In 2011, the “Safe” association began experimenting with an alternative equipment access programme through the postal service. Users call or email the association, which assesses their use and needs and ensures that users are followed by a professional (without this being a factor of non-access to the postal service). The syringe exchange programme via the post sends customised drug use equipment free of charge. They also deliver a prevention message and refer users to a CAARUD or CSAPA when requested or possible. In 2016, a little more than 270,000 syringes were dispensed as part of the postal needle and syringe exchange programme (SEP). Slightly over a thousand users have benefited from the programme since it was introduced in 2011. The main reasons for users turning to this scheme include: remote geographical location, inconvenient HR scheme opening hours, need for specific equipment not available in CAARUDs or CSAPAs, the desire for confidentiality, difficulties experienced by users in discussing their opioid substitution medication injecting practices,… (De Postis 2013; Duplessy and Pourchon 2015).

[5] Prevention kits are intended to limit the risks of transmitting infectious diseases among injecting drug users. These kits comprise 2 syringes, 2 alcohol wipes, 2 bottles of sterile water, 2 sterile aluminium containers (to replace spoons), a cotton filter, a dry wipe (to dab the injection site after administration), 1 condom, instructions for use and general prevention messages.

c) Distribution of equipment and drug use paraphernalia beyond syringes/needles

The availability of prevention material has gradually been extended to administration routes other than injection, with the distribution of snort kits and basing kits for crack smokers and the distribution of special foils for users who “chase the dragon” (inhaling the vapours produced by heating the substance placed on aluminium foil). Finally, distributing condoms (and encouraging their use) also helps reduce HIV virus contamination.

Type of equipment	routinely available	often available, but not routinely	rarely available, available in limited number of settings	equipment not made available	information not known
pads to disinfect the skin	X				
dry wipes	X				
water for dissolving drugs	X				
sterile mixing containers	X				
filters	X				
citric/ascorbic acid	X				
bleach				X except in prison	
condoms	X				
lubricants	X				
low dead-space syringes	X				
HIV home testing kits	X				
non-injecting paraphernalia: foil, pipes, straws	X				
List of specialist referral services: e.g. drug treatment; HIV, HCV, STI testing and treatment	X				

d) Naloxone distribution programme

As regards the implementation of a naloxone distribution programme in France, in February 2015, the Commission on narcotics and psychotropic substances voted in favour of the nasal route of administration for naloxone by drug users and third parties. Priority users are newly released inmates together with users after opioid withdrawal (ANSM 2016). Naloxone for nasal use has been exempted from list I of poisonous substance [Arrêté du 13 octobre 2015 modifiant l’arrêté du 22 février 1990 portant exonération à la réglementation des substances vénéneuses destinées à la médecine humaine]. Consequently, dispensing does not require a medical prescription; however, it is still a medication only available in pharmacies.

The proprietary medicinal product Nalscue® (naloxone for nasal use) from the pharmaceutical company Indivior was granted a cohort temporary authorisation for use (ATU) in November 2015 (ANSM 2015). It has been available since July 2016 [Arrêté du 26 juillet 2016 modifiant l’arrêté du 17 décembre 2004 modifié fixant la liste prévue à l’article L. 5126-4 du code de la santé publique]. Only physicians practising in a CSAPA setting, in hospital addiction medicine departments, in emergency departments, in any other departments in which an hospital-based addiction liaison and treatment team (ELSA) operates and in prison treatment units may include patients in the cohort ATU. Supply is reserved for pharmacists in charge of dispensing within hospital pharmacies and hospital CSAPA. Since May 2017, the dispensing of naloxone kits is also authorised in CAARUD. However, kits are not available in community/primary care pharmacy. Marketing authorisation for Nalscue® (0.9 mg/0.1 ml naloxone) was granted in July 2017. Taking into account the diversity of the characteristics of opioids that are currently used, the overdose risk may differ and it is sometimes necessary, depending on the clinical context, to administer higher doses of naloxone and to repeat the process to prolong its action (Frauger *et al.* 2018).

From August 2016 to December 2017, 343 physicians enrolled in the ATU (temporary authorization for use) cohort scheme (166 of whom included at least 1 client), 302 dispensing physicians or pharmacists were enrolled, 1,623 clients were included and 1,057 Nalscue® kits were distributed. Over the given period, 23 people received Nalscue®: 21 clients who had overdosed (5 clients included in the ATU and 16 third parties) and 2 clients who were included in the ATU who self-administered Nalscue® without any overdose symptoms but who developed signs of opioid withdrawal. No adverse reactions were reported in people who received Nalscue®. A Parisian CSAPA reported on a cohort ATU for intranasal naloxone, highlighting the obstacles posed by the delivery methods associated with ATU and the importance of educating clients and their families about its use (Barré *et al.* 2018). The ATU ended on 8 January 2018 (ANSM and INDIVOR UK Ltd 2018). The HAS Transparency Commission gave a favourable opinion on its inclusion on the list of special cases that can be reimbursed to social security contributors (with a proposed reimbursement rate of 65%) and on the list of special cases approved for community use (HAS 2018b). It considered that Nalscue® slightly improved the medical service provided in the emergency treatment for opioid overdoses (HAS 2018b). From January 2018 to April 2019, 5,000 Nalscue® kits were ordered. In the absence of an agreement with the Economic Committee for Healthcare Products on the price of Nalscue®, The Indivior laboratory plans to no longer market this drug after stocks run out (21,000 kits that will expire in December 2020) (Guillou *et al.* 2019).

Since June 2019, intramuscular naloxone kits (0.91 mg/ml Prenoxad®, marketed by Ethypharm) have been available in pharmacists for 23 euros and in specialised facilities. This kit, whereby 65% can be reimbursed when prescribed, can also be purchased without a prescription. It comes in the form of a pre-filled marked syringe: with each mark corresponding to a 0.4 ml dose. A syringe contains 5 doses (i.e. a 2 ml solution in total). The kit contains 2 needles in case the first one is damaged. The HAS Transparency Commission considered that Prenoxad® did not improve the medical service provided in the emergency treatment for opioid overdoses (HAS 2018a).

e) Drug consumption rooms

The trialling of drug consumption room (DCR) is laid down in Article 43 of the 2016 law on health system reform [Loi n°2016-41 du 26 janvier 2016 de modernisation de notre système de santé]. This article stipulates that persons in possession of and consuming narcotic substances for their own personal use in a DCR cannot be prosecuted for illegal use and possession. Professionals working at a DCR and acting in accordance with their supervisory duties are also protected from prosecution for being complicit or facilitating the illegal use of narcotics.

The specifications for DCR, laid down by the decree of 22 March 2016 [Arrêté portant approbation du cahier des charges national relatif à l'expérimentation d'espaces de réduction des risques par usage supervisé], was modified in July 2019 [Arrêté du 15 juillet 2019 modifiant l'arrêté du 22 mars 2016 portant approbation du cahier des charges national relatif à l'expérimentation d'espaces de réduction des risques par usage supervisé]. It describes in detail the general and specific objectives (the first of which is to help reduce the risk of overdose and infections), the duration of the trial (6 years), the facilities concerned (the CAARUD are entrusted with running the DCR but in separate premises from their normal missions), the targeted population (vulnerable drug users, aged over 18 years, with multiple risk factors), the administration routes (injecting, snorting, inhaling), the location (close to areas of drug use), funding, national supervision, together with the objectives and methods for evaluation.

At local level, these specifications describe the missions of the DCR, the layout of the various spaces, the equipment to be supplied, the operation of the room together with the regulations, the protocols and resources to be set in place, the composition of the team, partnerships and

state health service contracts, participation in the surveillance and health alert system, the local steering committee and the scientific and cost-related evaluation of the scheme.

The scientific evaluation of the trial, conducted by the National Institute of Health and Medical Research (INSERM, see Research workbook) will notably focus on its impact on public health. A cohort of drug users, COSINUS (cohort for the evaluation of drug consumption rooms) will be recruited and the impact of the room will be studied with efficacy endpoints such as the reduction in high-risk practices for the transmission of HCV and HIV, together with the improvement in mental health, socioprofessional integration, access to accommodation and treatment, and the reduction in criminal acts. The evaluation will also focus on the social acceptability of the HR measures and the reduction of nuisance in public spaces (Auriacombe *et al.* 2019).

The medico-economic evaluation of the DCR will be carried out by the INSERM SESSTIM U1252 team. This study will provide data on the cost of implementing DCR as well as the benefits of this intervention in terms of the infections and overdoses that were avoided, the costs avoided with regards to managing these health problems and cost-effectiveness. The model developed in this study will also make it possible to simulate the intervention's long-term health benefits, particularly with regard to HIV, HCV, abscesses and overdoses.

The Paris drug consumption room, run by the Gaïa association [Arrêté du 25 mars 2016 portant désignation du CAARUD Gaia], has been open since 17 October 2016. It is located in the Gare du Nord area, near to where a growing drug use scene has developed in the past ten or so years. The room, located in a building at the *Lariboisière* hospital, but with a separate entrance, is open 7 days a week from 13:30 to 20:30 and comprises a counselling room, twelve spaces for injection (20 minutes maximum per injection), four for inhalation (30 minutes maximum per inhalation), a cubicle reserved for education on injection risks, a rest room, offices for social and medical appointments, and a room for social integration activities. At least five workers are present at the same time. The team consists of a department manager (1 full-time equivalent - FTE), educators (13 FTE), nurses (7 FTE), a doctor (0.5 FTE plus one weekly session by a psychiatrist), a social worker (1 FTE), an administrative position (0.5 FTE), peer workers and voluntary workers, together with a mediator (security staff, 2 FTE).

From October 2016 to March 2019, the drug consumption room hosted 1,250 different people, and recorded 150,000 visits, including 111,000 injections. The number of clients appears to stabilise at 170 visits per day on average (with a peak of more than 200 visits once per week) (Le Bourhis 2019). The people admitted in the first year were 37.8 years old on average, 90% were men, of which 40% were destitute, 59% lived in substandard housing or without a fixed address, 31% were medically uninsured and 41% had already been monitored for addiction. The two most widely used substances are Skénan® (morphine sulphate), injected during 47% of visits, and inhaled crack (28% of visits) or injected crack (10%). Buprenorphine injection is observed more rarely (7% of visits), along with methadone (injected alone in 5% of visits and combined with injected crack in 2% of visits). Intravenous heroin is reported for 1.5% of visits.

76 cases of malaise or overdose occurred, requiring the emergency services to be called (ER) or intensive care on 34 occasions. Narcan® was administered in 5 cases at the DCR and once in the ER. The room offers medical or nursing appointments (527 medical appointments took place for 244 different users and 1,156 nursing procedures for 288 users, 70 cases of physical assistance during appointments, hospital admissions and for examinations, 40 vaccinations - influenza and hepatitis A), social appointments (1,152 appointments took place for 243 different users, 200 users benefited from the weekly presence of the National Health Insurance Fund, with 165 cases of clients receiving physical assistance for social and legal procedures) and screening for HIV, HCV and HBV offered routinely or during testing-week. 96 rapid diagnostic tests (RDT) for HIV (3 of which were positive), 75 RDT for HCV (13 of which were positive), 36 blotting paper tests (19 of which were positive for HCV RNA and 1 for HIV) and 27 Fibroscan® exams (a non-invasive machine that can instantly detect liver fibrosis and

assess its degree of advancement) were performed. Lastly, 7 patients completed treatment for hepatitis C. Rounds were stepped up (9 per week, including 2 in the morning), enabling 3,842 contacts with users, collection of syringes and responses to resident requests. The room regularly organises open-door events in the mornings for the general public, with an information and mediation role (Avril 2017, 2018).

The second DCR run by the Ithaque association [Arrêté du 25 mars 2016 portant désignation du CAARUD Ithaque], opened in Strasbourg on 7 November 2016. It is open from 13:00 to 19:00, 7 days a week, and is located on the site of Hôpital Civil. The room consists of four main areas: a reception area, a waiting room, a consumption room with six injection spaces, four inhalation spaces and two spaces for snorting, and a rest room. There are 3 additional offices reserved for medical appointments, psychologist or social worker appointments or individual interviews. In 2017, the room admitted 271 different users in the space for using (74% men, 24% women - including 3 pregnant women - and 1% transgender people), with 6,621 visits during the year. The average age of the people admitted in 2017 was 37 years old. 11% were destitute, 26% were living in sub-standard housing or without a fixed address, and 7% were medically uninsured. Cocaine is the main substance used ahead of Skénan®, buprenorphine, heroin, crack-freebase and speedball. 34% of users are prescribed OST. Patterns of use are injection (in 84% of cases), smoking, snorting and inhalation. Five overdoses required intervention by the emergency services, all with a positive outcome. As regards infectious diseases, 22% of users are seropositive for HCV, 2.5% for HBV and 1.3% for HIV. In terms of screening, 238 RDT were performed (94 HIV, 87 HCV and 57 HBV) together with 59 Fibroscan® resulting in the diagnosis of 13 patients seropositive for HCV (with 5 users unaware of their status) and no patients seropositive for HIV or HBV. The needle and syringe exchange programme run by the room dispensed 109,000 syringes (Association Ithaque 2017; Bader 2018).

The EROPP survey (Survey on representations, opinions and perceptions regarding psychoactive drugs) conducted in 2018 on a representative sample of the French population aged 18 to 75, included several opinion questions on DCR. DCR were presented as "spaces reserved for people who inject drugs, where they can come to use the substances they bring in good sanitary conditions and in the presence of trained staff in order to avoid overdoses and infections and to prevent them from injecting in public places". 82% of respondents had already heard of these rooms before the survey and 80% thought it was a good thing that France has these two rooms (especially if they had already heard about them). Finally, 76% of respondents believed "that it would be necessary today to open rooms like this in other cities in France" (Spilka *et al.* 2019).

The 2018-2022 national action plan on addictions will continue to adapt the schemes already authorised, with a view to strengthening them and overcoming any difficulties encountered. The plan also envisages creating other facilities to cater for unmet needs, including in the Ile-de France region.

f) Harm reduction measures on release from prison

See paragraph c) of section T1.5.3 in the 2017 Harms and harm reduction workbook and also section T1.3.2 of the 2018 Prison workbook.

g) Hepatitis B vaccination and campaigns targeted at PWID

As regards hepatitis B prevention, vaccination of all infants has been compulsory since January 2018. This measure is part of the 2018-2022 National Health Strategy (Ministère des solidarités et de la santé 2017).

The hepatitis B vaccine is provided free of charge by CeGIDD (free information, screening and diagnosis centre) and CSAPAs. This vaccine is 65% reimbursed by the National Health Insurance Fund (*Assurance maladie*) as part of a general care system.

h) Infectious diseases treatment and care

A number of CSAPAs offer advanced clinics in the field of liver disease (to assess hepatitis C, and introduce treatment and follow-up).

In 2016, in France, the total number of people with chronic hepatitis C was estimated to be 133,500 (95% CI: 56,880-312,626), representing a prevalence of 0.30% (95% CI: 0.13-0.70), according to the Barotest results (see section T5. On Sources). Prevalence among people who have experimented with intravenous drugs was estimated to be 12.1% (95% CI: 2.9/-38.4). In the general population, 81% (95% CI: 44-96) of people with chronic hepatitis C knew they had it, i.e. there were 25,900 undiagnosed people (95% CI: 5,873-74,474) (Brouard 2019). In 2014, before direct-acting antivirals (DAA) became available, this population was estimated at 175,000 (Razavi *et al.* 2014). Between January 2014 and December 2017, 59,000 patients started DAA treatment, for 3.5 billion euros, that was reimbursed by the National Health Insurance Fund (Dessauce *et al.* 2019). Among the beneficiaries who had been reimbursed for a drug substitution treatment over the last 12 years (proxy of the population who currently or previously injected drugs), nearly 11,000 were treated by DAA between their appearance in 2014 and 2017, i.e. nearly one in five people were treated by these new drugs out of the general population (Brisacier 2019b).

i) Sexual health counselling & advice, condom distribution

Preventing sexual risks through a comprehensive sexual health approach (vaccination, sex education, preventing unwanted pregnancies by prescribing contraception or issuing emergency contraception, detecting violence related to sexuality or gender identity and sexual disorders and dysfunctions) is at the heart of CeGIDD's goals.

Condom distribution is also one of CAARUD's and CSAPA's harm reduction goals. In addition, prevention kits (Steribox®), sold in community pharmacies, contain a condom.

j) Preventing first-time injection

See paragraph f) of section T1.5.3 in the 2018 Harms and harm reduction workbook.

k) Support and education on injection-related harm

See paragraph g) of section T1.5.3 in the 2017 Harms and harm reduction workbook.

T1.5.4. Trends: Please comment on current trends regarding harm reduction service provision (suggested title: Harm reduction services: availability, access and trends)
Trends: Syringe trends: Please comment on the possible explanations of short term (5 years) and long term trends in the numbers of syringes distributed to injecting drug users, including any relevant information on changes in specific sub-groups, and changes in route of administration.

In France, the two main channels for the distribution of syringes are CAARUDs and community pharmacies. Together, these distribute 90% of syringes made available to injecting drug users. These two aggregate data sources appear to reflect a slight increase in the changes between 2008 and 2016 in the total volume of syringes distributed. The decline in pharmacy syringe sales is offset by the large increase in the number of syringes distributed in CAARUD. These trends should be interpreted with caution, owing to the numerous gaps in data over the period studied.

Furthermore, CSAPAs have been required to dispense harm reduction materials since 2008, but no data were collected until 2014. Since then, the provision of prevention materials by CSAPAs has remained somewhat stable (390,000 syringes in 2014, compared to 430,000 in 2015 and 2016).

As regards the other two sources that complement the national supply mechanism for harm reduction equipment, the supply of syringes via automatic distribution machines has remained relatively stable since 2008, and the postal NSP has increased spectacularly since it was first introduced (variation of approximately +400% between 2012 and 2016); however, these distribution channels only represent 4% and 2% of the total volume, respectively.

The available data thus point to a slight increase; however, the total volume of syringes distributed in France still appears to be insufficient to guarantee good syringe coverage for injecting drug users (threshold for good coverage > 200 syringes per injecting drug user).

Note that, in 2015, the OFDT estimated the number of past-year injecting drug users at 100,000. Compared with the estimates put forward for 2006, the prevalence of past-month injecting practices remains stable, while prevalence in France remains below the average European levels (Costes 2009; Janssen 2016, 2018).

T1.5.5. ***Optional****. Please provide any additional information you feel is important to understand harm reduction activities within your country. Information on services outside the categories of the 'treatment system map' may be relevant here (e.g. services in pharmacies/dedicated to HIV/AIDS, primary health care system/GPs, or other sites and facilities providing testing of infectious diseases to significant number of people who use drugs, or drugs/outreach activities not covered above) (suggested title: Additional information on harm reduction activities)*

T1.6. Targeted interventions for other drug-related health harms

The purpose of this section is to provide information on any other relevant targeted responses to drug-related health harms

T1.6.1. ***Optional****. Please provide additional information on any other relevant targeted health interventions for drug-related health harms (suggested title: Targeted interventions for other drug-related health harms)*

T1.7. Quality assurance of harm reduction services

The purpose of this section is to provide information on quality system and any national harm reduction standards and guidelines.
Note: cross-reference with the Best Practice Workbook.

T1.7.1. ***Optional****. Please provide an overview of the main harm reduction quality assurance standards, guidelines and targets within your country (suggested title: Quality assurance for harm reduction services)*

Quality assurance for harm reduction services
See T1.7.1 of the 2017 workbook on Harms and harm reduction.

T1.7.2. ***Optional****. Please comment on the possible explanations of long term trends and short term trends in any other drug related harms data that you consider important (suggested title: Additional information on any other drug related harms data)*

T2. Trends Not relevant in this section. Included above.

T3. New developments

The purpose of this section is to provide information on any notable or topical developments observed in drug related harms and harm reduction in your country **since your last report.** T1 is used to establish the baseline of the topic in your country. Please focus on any new developments here.
If information on recent notable developments have been included as part of the baseline information for your country, please make reference to that section here. It is not necessary to repeat the information.

T3.1. Please report on any notable new or topical developments observed in drug related deaths and emergencies in your country since your last report (suggested title: New developments in drug-related deaths and emergencies)

The National narcotics and psychotropic substances commission, who met on 11 October 2018, proposed measures to reduce the number of overdoses (ANSM 2018). The main measures were:

- standardising access to health care service accessibility throughout the territory;
- making all forms of ready to use naloxone widely available;
- updating guidelines issued by the French Federation of Addiction Care in 2004 on therapeutic strategies for people dependent on opiates (making room for substitution treatments);
- providing information about the risks of overdosing on opioid substitution medications by circulating existing information leaflets;
- increasing the number of health professionals involved in managing opioid-dependent clients;
- establishing a legal protection system for people offering help to others in danger after consuming illegal substances, so that the person who is helping does not hesitate to call for help for fear of legal proceedings.

T3.2. Please report on any notable new or topical developments observed in drug related infectious diseases in your country since your last report (suggested title: New developments in drug-related infectious diseases)

New developments in drug-related infectious diseases
See T1.5.1 of this workbook.

T3.3. Please report on any notable new or topical developments observed in harm reduction interventions in your country since your last report (suggested title: New developments in harm reduction interventions)

The amendment of the DCR specifications, by legislative order of 15 July 2019 [Arrêté modifiant l'arrêté du 22 mars 2016 portant approbation du cahier des charges national relatif à l'expérimentation d'espaces de réduction des risques par usage supervisé, autrement appelés « salles de consommation à moindre risque »], expands DCR access to users who inhale or smoke substances. Previously, these users could only access an inhalation station after having injected a product during an earlier visit to these rooms.

T4. Additional information

The purpose of this section is to provide additional information important to drug related harms and harm reduction in your country that has not been provided elsewhere.

T4.1. ***Optional****. Please describe any important sources of information, specific studies or data on drug related harms and harm reduction, that are not covered as part of the routine monitoring. Where possible, please provide published literature references and/or links (suggested title: Additional Sources of Information.)*

T4.2. ***Optional****. Please use this section to describe any aspect of drug related harms and harm reduction that the NFP value as important that has not been covered in the specific questions above. This may be an elaboration of a component of drug related harms and harm reduction outlined above or a new area of specific importance for your country (suggested title: Further Aspects of Drug-Related Harms and Harm Reduction)*

T5. Sources and methodology

The purpose of this section is to collect sources and bibliography for the information provided above, including brief descriptions of studies and their methodology where appropriate.

T5.1. Please list notable sources (including references to reports and grey literature) for the information provided above (suggested title: Sources)

DRD: Please describe the monitoring system to complement ST5/ST6 (clarify source GMR, SR, other; coverage; ICD coding; underestimation; underreporting and other limitations).

Emergencies: please provide the case definition for reporting drug-related emergencies and, if applicable, an overview of the monitoring system in place and important contextual information, such as geographical coverage of data, type of setting, case-inclusion criteria and data source (study or record extraction methodology).

DRID: Please describe the national surveillance approach for monitoring infectious diseases among PWID. Please describe the methodology of your routine monitoring system for the prevalence of infectious diseases among PWID as well as studies out of the routine monitoring system (ad-hoc). Be sure that in your description you include all necessary information for the correct interpretation of the reported data, i.e.: clarify current sources, ad-hoc and/or regular studies and routine monitoring, settings, methodology of major studies. Representativeness and limitations of the results.

Harm Reduction: Please describe national or local harm reduction monitoring approaches and data flow, incl. syringe monitoring. *Where possible, provide any contextual information helpful to understand the information on needle and syringe programmes, drug consumption rooms and take-home naloxone programmes reported in ST 10 "Harm Reduction". Such context can be: statutory evaluation requirements, reports to funding bodies, research projects.*

Provide references of policy documents relevant to the reduction of drug-related health harm.

Sources

Drug-related deaths

See the description of sources on drug-related death in section T5.1 of the **2017** Harms and harm reduction workbook.

Drug-related hospital emergency presentations

See the description of sources on drug-related hospital emergency presentations in section T5.1 of the **2018** Harms and harm reduction workbook.

Harm reduction

See the description of sources on harm reduction in section T5.1 of the **2018** Harms and harm reduction workbook.

Viral hepatitis (Hepatitis B and C)

See the description of sources on viral hepatitis among drug users in section T5.1 of the **2017** Harms and harm reduction workbook.

VIH/sida

HIV/AIDS surveillance system
Santé publique France - SpF (French Public Health Agency)

Notification of new AIDS cases has been mandatory since 1986. The new HIV diagnoses were introduced in 2003. HIV data is the combination of biological information from biologists and epidemiological and clinical information from clinical physicians. AIDS notifications, which are anonymised from the outset, are only sent by physicians.

Since 2003, around 2,500 biologists and 16,000 clinicians have participated in mandatory HIV and/or AIDS reporting. Virological surveillance (Elisa test based on detecting specific antibodies) is carried out at the same time by the National HIV Reference Centre.

Since April 2016, biologists and clinicians have been required to report their diagnoses online via the e-DO web application (www.e-do.fr). To estimate the actual number of HIV-positive test results, data must be adjusted to take into account under-reporting (around 30%), missing data and reporting delays. As reporting behaviours have changed as a result of the shift from paper to online reporting, the data correction method has had to be adapted. The current method has been applied retrospectively to all cases diagnosed since 2010 in order to analyse temporal developments. This method resulted in a higher number of estimated HIV-positive discoveries than previously produced.

Barotest 2016
Santé publique France - SpF (French Public Health Agency)

The Health Barometer is a telephone survey, that has been repeated regularly since 1992, by taking a random sample compared to a representative sample of the general metropolitan population aged 15-75, with the aim to monitor the main behaviours, attitudes and perceptions regarding risk taking and the state of health of the population residing in France.

In 2016, infectious diseases was one of the survey's main subjects, including testing for HCV, HBV and HIV throughout life, the HBV vaccination and major high-risk exposures to HCV, HBV and HIV. A virological component called "Barotest" has been linked to the Health Barometer. At the end of the interview, participants over 18 with social coverage were offered free HCV, HBV and HIV testing by taking a sample of their own blood at home on blotting paper (research on anti-HCV antibody, HCV RNA, HBsAg, anti-HIV antibody) (Lydié *et al.* 2018). In the event that the test came back negative, the result was sent to the participant and his or her attending physician. In the event that the test(s) came back positive, the result was sent to the physician and a letter was sent to the participant inviting them to consult their attending physician. Nearly four in ten people (39%) who were offered the "Barotest" accepted, i.e. 6,945 people.

Bibliography

AFEF (2018). Recommandations AFEF pour l'élimination de l'infection par le virus de l'hépatite C en France. AFEF (Association française pour l'étude du foie), Paris. Available: https://afef.asso.fr/wp-content/uploads/2018/06/VF-INTERACTIF-RECO-VHC-AFEF-v2103.pdf [accessed 05/09/2019].

Allibe, N., Billault, F., Moreau, C., Marchard, A., Gaillard, Y., Hoizey, G. *et al.* (2019) Ocfentanil in France: seven case reports (2016-2018). Toxicologie Analytique et Clinique 10/01/2019, 10.1016/j.toxac.2018.12.003.

ANSM (2015). Compte rendu de la séance n°21 du 26 novembre 2015. Commission évaluation initiale du rapport entre les bénéfices et les risques des produits de santé. Agence nationale de sécurité du médicament et des produits de santé, Saint-Denis. Available: https://ansm.sante.fr/var/ansm_site/storage/original/application/3547b9b460e4ad0571cbae84e8fc19c5.pdf [accessed 08/08/2019].

ANSM (2016). Retour sur la séance du 14 avril 2016 de la Commission des stupéfiants et psychotropes. ANSM (Agence Nationale de Sécurité du Médicament et des produits de santé), Saint-Denis. Available: https://www.ansm.sante.fr/var/ansm_site/storage/original/application/5614fdab02edff58f6b823defcfd41da.pdf [accessed 09/08/2019].

ANSM (2018). Commission des stupéfiants et psychotropes. Compte rendu de la séance n° 11 du 11 octobre 2018. Agence nationale de sécurité du médicament et des produits de santé, Saint-Denis. Available: https://www.ansm.sante.fr/content/download/160569/2102709/version/2/file/CR_COM_STUP-111018.pdf [accessed 09/08/2019].

ANSM and INDIVOR UK Ltd (2018). Autorisation temporaire d'utilisation de cohorte. Résumé du rapport de synthèse périodique n°13. Nalscue 0,9 mg/0,1 ml, solution pour pulvérisation nasale en récipient unidose. Période du 25/09/2017 au 07/01/2018. Available: http://ansm.sante.fr/var/ansm_site/storage/original/application/5c8d832400b3de2f650f567b1f5a877b.pdf [accessed 09/08/2019].

Association Ithaque (2017). Argos, salle de consommation à moindre risque de Strasbourg. Bilan d'activité de la première année de fonctionnement. Available: http://www.perseus-web.fr/nar6/uploads/scmr-argos-bilan-a-a-un-an-vd-2017-11-22.pdf [accessed 19/06/2019].

Auriacombe, M., Roux, P., Briand Madrid, L., Kirchherr, S., Kervran, C., Chauvin, C. *et al.* (2019). Impact of drug consumption rooms on risk practices and access to care in people who inject drugs in France: the COSINUS prospective cohort study protocol. BMJ Open 9 (2) e023683.

Avril, E. (2017). Espace GAIA, first DCR in Paris since October 2016: first results and perspectives In: Drug-related infectious diseases expert meeting, 15 June 2017, EMCDDA, Lisbon. Available: http://www.emcdda.europa.eu/system/files/attachments/4661/Espace%20Gaia%2C%20First%20DCR%20in%20Paris%20since%20October%202016-%20first%20results%20and%20perpectives%20-%20Elisabeth%20Avril%2C%20Association%20Gaia%20Paris.pdf [accessed 09/08/2019].

Avril, E. (2018). Salle de consommation à moindre risque Jean-Pierre LHOMME - Espace GAIA, Paris. Bilan d'activité. Commission des stupéfiants et des psychotropes, Séance n° 10. Compte rendu de la séance du 5 avril 2018. ANSM, Saint-Denis.

Bader, D. (2018). Salle de consommation à moindre risque Argos. Association Ithaque, Strasbourg. Bilan d'activité. Commission des stupéfiants et des psychotropes, Séance n° 10. Compte rendu de la séance du 5 avril 2018. ANSM, Saint-Denis. Available: https://www.ansm.sante.fr/var/ansm_site/storage/original/application/fc33ec0d495a999727675a2d141306fd.pdf [accessed 09/08/2019].

Barré, T., Vorspan, F., Fortias, M., Veyrier, M., Cavagna, P., Azuar, J. *et al.* (2018). Pratique de l'ATU de cohorte de la naloxone intranasale (Nalscue®) : mise en place dans un CSAPA parisien [Temporary approval for intranasal naloxone: Setting up in a French addiction center]. Thérapie 73 (6) 495-500.

Brisacier, A.-C. (2019a). Recours aux urgences pour usage de substances illicites. Alcoologie et Addictologie 41 (1) 14-21.

Brisacier, A.-C. (2019b). Tableau de bord « Traitements de substitution aux opioïdes ». Mise à jour 2019. OFDT, Paris. Available: https://www.ofdt.fr/BDD/publications/docs/TabTSO190308.pdf [accessed 19/06/2019].

Brisacier, A.-C., Palle, C. and Malalret, M. (2019). Décès directement liés aux drogues. Tendances. OFDT (133). Available: https://www.ofdt.fr/publications/collections/periodiques/lettre-tendances/deces-directement-lies-aux-drogues-tendances-133-juillet-2019/ [accessed 09/08/2019].

Brouard, C. (2019). Hépatites B et C : dernières données épidémiologiques. In: Journées francophones d'hépato-gastroentérologie et d'oncologie digestive, 22 mars 2019, Paris.

Brouard, C., Pillonel, J. and Lot, F. (2019). Elimination de l'hépatite C. Données épidémiologiques en France. In: Réunion ANRS AC46, Paris.

Brouard, C., Pioche, C., Léon, L., Lot, F., Pillonel, J. and Larsen, C. (2016). Incidence et modes de transmission de l'hépatite B aiguë diagnostiquée en France, 2012-2014 [Incidence and routes of transmission of acute hepatitis B diagnosed in France, 2012-2014]. BEH - Bulletin Épidémiologique Hebdomadaire (13-14) 237-243.

Cadet-Taïrou, A., Saïd, S. and Martinez, M. (2015). Profils et pratiques des usagers des CAARUD en 2012 [CAARUD client profiles and practices in 2012]. Tendances. OFDT (98). Available: https://www.ofdt.fr/BDD/publications/docs/eftxacv1.pdf ; http://en.ofdt.fr/publications/tendances/caarud-client-profiles-and-pratices-2012-tendances-98-january-2015/ [accessed 12/08/2019].

CEIP-A Grenoble (2019). DRAMES (Décès en relation avec l'abus de médicaments et de substances). Principaux résultats de l'enquête 2017. ANSM, Saint-Denis. Available: https://www.ansm.sante.fr/var/ansm_site/storage/original/application/6d3b20150fdf3c980805abf5a27e2f02.pdf [accessed 11/06/2019].

Costes, J.-M. (2009). Prévalence de l'usage problématique de drogues en France : estimations 2006. Tendances. OFDT (69). Available: http://www.ofdt.fr/ofdtdev/live/publi/tend/tend69.html [accessed.

Cour des comptes (2019). La prévention et la prise en charge du VIH. Communication à la commission des affaires sociales du Sénat. Cour des Comptes, Paris. Available: https://www.ladocumentationfrancaise.fr/rapports-publics/194000571/index.shtml [accessed 09/08/2019].

De Postis, R. (2013). Safe, le programme d'échange de seringues postal : un vrai besoin. Le Courrier des Addictions 15 (4) 22-25.

Delile, J.-M., de Ledinghen, V., Jauffret-Roustide, M., Roux, P., Reiller, B., Foucher, J. *et al.* (2018a). Hepatitis C virus prevention and care for drug injectors: the French approach. Hepatology, Medicine and Policy 3 (7).

Delile, J.-M., Lang, J.-P., Remy, A.-J. and Rosa, I. (2018b). Livre Blanc sur l'accès aux soins des populations vulnérables pour l'hépatite C. Fédération Addiction, Paris. Available: https://www.federationaddiction.fr/parution-du-livre-blanc-de-lhepatite-c/ [accessed 08/08/2019].

Dessauce, C., Semenzato, L. and Barthélémy, P. (2019). Les antiviraux à action directe dans le traitements de l'hépatite C : retour sur 4 ans de prise en charge par l'Assurance Maladie. Points de repère. Assurance Maladie, 52. Available: https://www.ameli.fr/fileadmin/user_upload/documents/Points_de_repere_n_52_-_Les_antiviraux_a_action_directe_dans_le_traitement_de_l_hepatite_C.pdf [accessed 09/08/2019].

Deuffic-Burban, S., Huneau, A., Verleene, A., Brouard, C., Pillonel, J., Le Strat, Y. *et al.* (2018). Assessing the cost-effectiveness of hepatitis C screening strategies in France. Journal of Hepatology 69 (4) 785-792.

Dhumeaux, D., ANRS and Association française pour l'étude du foie (AFEF) (2014). Prise en charge des personnes infectées par le virus de l'hépatite B ou de l'hépatite C. Rapport de recommandations 2014. EDP Sciences, Les Ulis. Available: https://solidarites-sante.gouv.fr/IMG/pdf/Rapport_Prise_en_charge_Hepatites_2014.pdf [accessed 19/06/2019].

Dhumeaux, D., Ministère des affaires sociales et de la santé, ANRS, Conseil national du sida et des hépatites virales (CNS) and Association française pour l'étude du foie (AFEF) (2016). Prise en charge thérapeutique et suivi de l'ensemble des personnes infectées par le virus de l'hépatite C. Rapport de recommandations 2016. EDP Sciences. Available: https://solidarites-sante.gouv.fr/IMG/pdf/rapport_.pdf [accessed 19/06/2019].

Díaz Gómez, C. (2018). Les CAARUD en 2015. Des inégalités dans l'offre de service de réduction des risques et des dommages. Tendances. OFDT (124). Available: https://www.ofdt.fr/index.php?cID=982 [accessed 09/08/2019].

Direction générale de la santé (2018). Priorité prévention : rester en bonne santé tout au long de sa vie. Comité interministériel de la Santé. Dossier de presse - 26 mars 2018. Ministère des solidarités et de la santé, Paris. Available: https://solidarites-sante.gouv.fr/IMG/pdf/plan_national_de_sante_publique__psnp.pdf [accessed 19/06/2019].

DREES (2015). Prévalence du VIH et du VHC chez les usagers de drogues fréquentant les structures de prise en charge et de réduction des risques. L'état de santé de la population en France. Direction de la recherche des études de l'évaluation et des statistiques,, Paris.

Duplessy, C. (2015). Rapport d'activité 2014. Association SAFE, Paris.

Duplessy, C. and Pourchon, F. (2015). Bilan de 3 ans d'expérimentation de la réduction des risques à distance (2011-2014). Association SAFE, Paris.

Euro-DEN (2015). Rapport final du projet Euro-DEN (Réseau européen des situations d'urgence associées aux drogues). Available: http://www.emcdda.europa.eu/attachements.cfm/att_250377_EN_Euro-DEN%20Final%20report%202015%20French.pdf [accessed 19/06/2019].

Euro-DEN Research Group and EMCDDA (2016). Hospital emergency presentations and acute drug toxicity in Europe. Update from the Euro-DEN Plus research group and the EMCDDA. Publications Office of the European Union, Luxembourg. Available: http://www.emcdda.europa.eu/publications/rapid-communications/2016/hospital-emergencies [accessed 09/08/2019].

Frauger, E., Kheloufi, F., Boucherie, Q., Monzon, E., Jupin, L., Richard, N. *et al.* (2018). Intérêt de la mise à disposition de la naloxone auprès des usagers de drogues pour le traitement d'urgence de surdosage d'opioïdes [Interest of take-home naloxone for opioid overdose]. Thérapie 73 (6) 511-520.

Groupe de travail FFA et AFEF (2019). Éliminer l'infection par le virus de l'hépatite C. Construire un parcours de soins coordonnés addictologues-hépatogastroentérologues pour les patients addicts. Parcours adapté aux besoins de chaque patient. Alcoologie et Addictologie 41 (1) 46-51.

Guillou, M., Doudet, E., Donnadieu-Rigole, H. and Benslimane, M. (2019). Naloxone, la difficile mise à disposition des kits anti-overdose. Le Flyer (75) 2.

HAS (2014). Place des tests rapides d'orientation diagnostique (TROD) dans la stratégie de dépistage de l'hépatite C. Recommandation en santé publique. Haute Autorité de Santé, Saint-Denis. Available: https://www.has-sante.fr//portail/upload/docs/application/pdf/2014-05/place_des_trod_dans_la_strategie_de_depistage_de_vhc-_rapport.pdf [accessed 19/06/2019].

HAS (2016). Place des tests rapides d'orientation diagnostique (TROD) dans la stratégie de dépistage de l'hépatite B. Recommandation en santé publique. Haute Autorité de Santé, Saint-Denis. Available: https://www.has-sante.fr//portail/upload/docs/application/pdf/2016-07/recommandatin_place_des_tests_rapides_dorientation_diagnostique_trod_dans_la_strategie_de_depistage_de_lhepatite_b.pdf [accessed 19/06/2019].

HAS (2017). Réévaluation de la stratégie de dépistage de l'infection par le VIH en France. Haute Autorité de Santé, Saint-Denis. Available: https://www.has-sante.fr/portail/upload/docs/application/pdf/2017-03/dir2/reevaluation_de_la_strategie_depistage_vih_-_recommandation.pdf [accessed 19/06/2019].

HAS (2018a). Commission de la transparence. Avis du 5 décembre 2018. Naloxone, Prenoxad. Haute autorité de santé, Saint-Denis.

HAS (2018b). Commission de la transparence. Avis du 7 février 2018. Nalscue 0,9 mg/0,1 ml, solution pour pulvérisation nasale en récipient unidose. Haute Autorité de Santé, Saint-Denis. Available: https://www.has-sante.fr/portail/upload/docs/evamed/CT-16512_NALSCUE_PIC_INS_Avis3_CT16512.pdf [accessed 19/06/2019].

HAS (2019a). Hépatite C : prise en charge simplifiée chez l'adulte. Fiche mémo. Haute Autorité de Santé, Saint-Denis. Available: https://www.has-sante.fr/portail/upload/docs/application/pdf/2019-03/fiche_memo_hepatite_c.pdf [accessed 14/06/2019].

HAS (2019b). Hépatite C : prise en charge simplifiée chez l'adulte. Rapport d'élaboration. Haute Autorité de Santé, Saint-Denis. Available: https://www.has-sante.fr/portail/upload/docs/application/pdf/2019-03/rapport_elaboration_hepatite_c.pdf [accessed 14/06/2019].

Hoareau, E. and Reynaud-Maurupt, C. (2018). Hépatite C : Renouvèlement des stratégies en CAARUD et CSAPA. Manuel méthodologique de réduction des risques, de soutien au dépistage et d'accompagnement vers le soin. RESPADD, Fédération Addiction, Paris. Available: https://www.federationaddiction.fr/du-nouveau-sur-le-vhc-une-annonce-ministerielle-et-un-guide-partenarial-pour-laccompagner/ [accessed 19/06/2019].

Janssen, E. (2016). Usagers de drogues pratiquant l'injection intraveineuse. Estimation 2014 en France métropolitaine. Note 2016-04. OFDT, Saint-Denis. Available: https://www.ofdt.fr/index.php?cID=903 [accessed 09/08/2019].

Janssen, E. (2018). Estimating the number of people who inject drugs: a proposal to provide figures nationwide and its application to France. Journal of Public Health (Oxf) 40 (2) e180-e188.

Lailler, G., Comboroure, J.-C., Florence, S., Troussier, T., Pilorgé, F. and Sarr, A. (2018). Premier bilan sur l'activité des CeGIDD, France, 2016. BEH - Bulletin Épidémiologique Hebdomadaire (40-41) 818-826.

Lapeyre-Mestre, M. and Boeuf-Cazou, O. (2011). Rôle du pharmacien dans la réduction des risques liés à la toxicomanie. Point de vue des patients sous médicaments de substitution aux opiacés (MSO) et des usagers de drogues. U1027 INSERM - Unité de Pharmacoépidémiologie de Toulouse - AFSSAPS-CEIP.

Le Bourhis, G. (2019). Dépistage et aller-vers. Comment amener au traitement ? In: Journée régionale Hépatite C en Ile-de-france de la Fédération addiction, Paris. Available: https://fr.calameo.com/read/00554485835559f9da78c?page=1 [accessed 09/08/2019].

Léon, L., Kasereka, S., Barin, F., Larsen, C., Weill-Barillet, L., Pascal, X. *et al.* (2017). Age- and time-dependent prevalence and incidence of hepatitis C virus infection in drug users in France, 2004-2011: model-based estimation from two national cross-sectional serosurveys. Epidemiology and Infection 145 (5) 895-907.

Lermenier-Jeannet, A., Cadet-Taïrou, A. and Gautier, S. (2017). Profils et pratiques des usagers des CAARUD en 2015 [CAARUD client profiles and pratices in 2015]. Tendances. OFDT (120). Available: https://www.ofdt.fr/BDD/publications/docs/eftxalxa.pdf ; https://en.ofdt.fr/index.php?cID=327 [accessed 09/08/2019].

Lot, F., Cazein, F., Bruyand, M., Pillonel, J., Sommen, C. and Lydie, N. (2019). Surveillance de l'infection à VIH (dépistage et déclaration obligatoire), 2010-2017. Bulletin de santé publique. Santé publique France (28 mars 2019).

Lydié, N., Saboni, L., Gautier, A., Brouard, C., Chevaliez, S., Barin, F. *et al.* (2018). Innovative approach for enhancing testing of HIV, hepatitis B, and hepatitis C in the general population: Protocol for an acceptability and feasibility study (BaroTest 2016). JMIR Research Protocols 7 (10) e180.

MILDECA (2018). Alcool, tabac, drogues, écrans : Plan national de mobilisation contre les addictions 2018-2022 [Alcohol, tobacco, drugs, screens: National plan for mobilisation against addictions 2018-2022]. Mission interministérielle de lutte contre les drogues et les conduites addictives, Paris. Available: https://www.drogues.gouv.fr/la-mildeca/le-plan-gouvernemental/mobilisation-2018-2022 [accessed 19/06/2019].

Ministère des affaires sociales et de la santé (2017). Stratégie nationale de santé sexuelle. Agenda 2017-2030. Ministère des affaires sociales et de la santé, Paris. Available: https://solidarites-sante.gouv.fr/IMG/pdf/strategie_nationale_sante_sexuelle.pdf [accessed 19/06/2019].

Ministère des solidarités et de la santé (2017). Stratégie nationale de santé 2018-2022. Ministère des solidarités et de la santé, Paris. Available: https://solidarites-sante.gouv.fr/IMG/pdf/dossier_sns_2017_vdefpost-consult.pdf [accessed 19/06/2019].

Ministère des solidarités et de la santé (2018). Feuille de route stratégie nationale de santé sexuelle 2018-2020. Ministère des solidarités et de la santé, Paris. Available: https://solidarites-sante.gouv.fr/IMG/pdf/feuille_de_route_pnsp_sante_sexuelle.pdf [accessed 20/06/2019].

Ministère des solidarités et de la santé (2019). Priorité prévention. Rester en bonne santé tout au long de sa vie. Prévenir et agir face aux surdoses opioïdes. Feuille de route 2019-2022. Ministère des solidarités et de la santé, Paris. Available: https://solidarites-sante.gouv.fr/IMG/pdf/strategie_prevention_des_surdoses_opioides-juillet_2019.pdf [accessed 01/08/2019].

Néfau, T. (2017). Le Point SINTES n° 3. OFDT, Saint-Denis. Available: https://www.ofdt.fr/BDD/sintes/LePointSINTES03.pdf [accessed 09/08/2019].

OFDT (2018). Séries statistiques : Évolution du nombre de nouveaux cas de sida liés à l'usage de drogues par voie injectable depuis 1995 [online]. Available: https://www.ofdt.fr/statistiques-et-infographie/series-statistiques/evolution-du-nombre-de-nouveaux-cas-de-sida-lies-l-usage-de-drogues/ [accessed 20/06/2019].

Pôle Indicateurs (2018). RECAP : REcueil Commun sur les Addictions et les Prises en charge. Tableaux statistiques 2007-2017. OFDT, Saint-Denis. Available: https://www.ofdt.fr/BDD/publications/docs/recap2007-17_series.pdf [accessed 13/06/2019].

Razavi, H., Waked, I., Sarrazin, C., Myers, R.P., Idilman, R., Calinas, F. *et al.* (2014). The present and future disease burden of hepatitis C virus (HCV) infection with today's treatment paradigm. Journal of Viral Hepatitis 21 (Suppl. 1) 34-59.

RESPADD (2018). Annuaire 2018 des Programmes d'échange de seringues en pharmacie (PESP). Available: https://www.respadd.org/wp-content/uploads/2018/10/Annuaire_PESP_2018_03_.pdf [accessed 10/09/2019].

Salomon, J. (2018). Discours d'ouverture du Pr Jérôme Salomon, Directeur général de la santé. In: Journée nationale de lutte contre les hépatites virales. Mardi 15 mai 2018, Ministère des solidarités et de la santé, Paris. Available: http://solidarites-sante.gouv.fr/IMG/pdf/discours_dgs_colloque15_mai_2018_def.pdf [accessed 08/08/2019].

Santé publique France (2018). Surveillance du VIH/sida. Données disponibles au 26 novembre 2018. Santé publique France, Saint-Maurice. Available: http://www.corevihest.fr/ckfinder/userfiles/files/Autres/Surveillance-VIH-sida.pdf [accessed 09/08/2019].

SFTA (2018). Recommandations de la SFTA pour la réalisation des analyses toxicologiques dans les cas de décès impliquant des NPS [SFTA guidelines for the achievement of toxicological analyzes for deaths involving NPS]. Toxicologie Analytique et Clinique 30 (1) 1-4.

SFTA (2019). Recommandations de la SFTA pour la réalisation des analyses toxicologiques dans les cas de décès impliquant des NPS - version 2019 [SFTA guidelines for the achievement of toxicological analyzes for deaths involving NPS - 2019 version]. Société française de toxicologie analytique. Available: https://www.sfta.org/articles/view/recommandations-de-la-sfta-pour-la-realisation-des-analyses-toxicologiques-dans-les-cas-de-deces-impliquant-des-nps-version-2019 [accessed 09/08/2019].

Spilka, S., Le Nézet, O., Janssen, E., Brissot, A., Philippon, A. and Chyderiotis, S. (2019). Drogues : perceptions des produits, des politiques publiques et des usagers. Tendances. OFDT (131). Available: https://www.ofdt.fr/BDD/publications/docs/eftxssz4.pdf [accessed 09/08/2019].

Vaux, S., Pioche, C., Brouard, C., Pillonel, J., Bousquet, V., Fonteneau, L. *et al.* (2017). Surveillance des hépatites B et C. Santé publique France, Saint-Maurice.

T5.2. Where studies or surveys have been used please list them and where appropriate describe the methodology (suggested title: Methodology)

Methodology

ANRS-Coquelicot: a multi-centre, multi-site study on the frequency and determining factors in practices that lead to a high risk of HIV and HCV transmission in drug users

National Institute for Health and Medical Research (Cermes3-Inserm U988) and Santé publique France (SpF)

The purpose of this study is to measure the prevalence of HIV and HCV infection in drug users through a face-to-face questionnaire and a blood sample taken by the user himself for biological testing. The study focuses on users' perceptions of their health and healthcare, use practices (substances and routes of administration), knowledge of transmission modes for HIV, HCV and HBV, and at-risk practices (e.g., context in which they first used drugs, sharing of equipment, use of condoms).

The first study was conducted in 2004 in five French cities (Lille, Strasbourg, Paris, Marseille and Bordeaux) on 1,500 users who had injected or snorted at least once in their life. In 2011, the sampling changed a bit: it was no longer cities, but urban areas, and two departments (Seine-Saint-Denis and Seine-et-Marne) were added; drug user recruitment focused on specialised services (CSAPAs, CAARUDs, residential structures) not including general medicine. This survey of took place between May and July 2011, and questioned 1,568 drug

users in 122 structures. The participation rate was 75%. Of these users, 92% agreed to provide a blood sample from their finger.

ENa-CAARUD: National survey of low-threshold structures (CAARUD)

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

Conducted every two or three years since 2006 in all CAARUDs (on mainland France and in French overseas departments), this survey determines the number of users seen in these structures, the characteristics of these users and their use patterns. Each user who enters into contact with the structure during the survey undergoes a face-to-face interview with someone working at the structure. The questions asked are on use (frequency, administration route, equipment-sharing), screening (HIV, HBV and HCV) and social situation (social coverage, housing, level of education, support from friends and family).

The 2015 survey was conducted from 14 to 27 September: 3,129 individuals completed the questionnaire and were included in the analysis. Out of the 167 CAARUDs registered in France, 143 took part in the survey (i.e. 86%). The data collection rate (proportion of users for whom the questionnaire was completed relative to all users encountered during the survey in the CAARUDs having taken part in the survey) was 64% in 2015.

EROPP: Survey on representations, opinions and perceptions regarding psychoactive drugs

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

Established in 1999, the EROPP telephone survey focuses on French people's representations and opinions on licit and illicit psychoactive substances, as well as any related public actions. The survey was conducted for the fifth time from 12 November to 18 December 2018, interviewing 2001 individuals. The survey relies on quota sampling, an empirical method adapted to small samples (2,000 individuals or less) even if theoretically the results cannot be applied to the whole population. The 2018 survey was limited to people aged between 18 and 75 (unlike the previous ones that questioned a population aged between 15 and 75).

The IFOP survey institute was in charge of the data collection, using the computer-assisted telephone interview system (CATI system). Two randomly generated sampling frames of telephone numbers were established, the first being made up of landline numbers (45%) and the second of mobile numbers (55%).

The sampling design is based on data from the INSEE employment survey. The data was ensured representativeness based on the following criteria: age and sex, socio-professional category of the respondent, the region where the house is located and the size of the city.

Mortality cohort study among drug users

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

A cohort of drug users seen in the specialised centres (CSAPA, CAARUD) was incorporated between September 2009 and December 2011 by the OFDT. One thousand individuals were included in 51 volunteers CAARUD and 17 volunteers CSAPA and responded to a questionnaire similar to that of the RECAP scheme. Their vital status was questioned in July 2013 and then again in December 2015. If appropriate, the causes of death are filled. This study describes the causes of death, calculates standardised mortality indices (Standardised Mortality Ratio), quantifies the years of life lost and identifies risk factors associated with the occurrence of death. The main limitation of a cohort study without longitudinal follow-up (excluding vital status) is to ignore developments on drug use and treatment of users after their inclusion in the study.

RECAP: Common Data Collection on Addictions and Treatments

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

This system was set up in 2005 and continually collects information about clients seen in National Treatment and Prevention Centres for Addiction (CSAPAs). In the month of April, each centre sends its results from the prior year to the OFDT, which analyses these results. The data collected relate to patients, their current treatment and treatments taken elsewhere, their uses (substances used and substance for which they came in the first place) and their health. The common core questions help harmonise the data collection on a national level and fulfil the requirements of the European Treatment Demand Indicator (TDI) protocol.

In 2017, approximately 208,000 patients seen in 260 outpatient CSAPAs, 15 residential treatment centres and 3 prison based CSAPAs for an addiction-related issue (alcohol, illicit drugs, psychoactive medicines, behavioural addiction) were included in the survey.