

Harms and harm reduction workbook

2020

France

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2020 National report (2019 data) to the EMCDDA by the French Reitox National Focal Point

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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. This number 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.

In 2018, 573 deaths were registered in the specific registers (464 in DRAMES added to the 109 deaths of DTA). According to the specific overdose death register (DRAMES scheme), 464 overdose deaths were registered in 2018 with opiates implicated in 76% of cases. Opioid substitution medications were implicated in 43% of cases and heroin in 28% 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).

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 2018, people infected through intravenous drug use represented 1% of new cases of HIV infection. The number of HIV seropositive diagnoses associated with drug use (67 cases in 2018) 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 (AC anti-VHC) 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 12.9 million syringes were distributed or sold to drug users in France in 2017. 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 33% increase (i.e. an increase of 3.2 million syringes between 2011 and 2017). Pharmacy syringe sales in the form of injection kits, which represent a quarter of syringes distributed to drug users in 2017, fell by a quarter (a 28% reduction between 2011 and 2017, i.e. 1.2 million fewer syringes), offset by the increase in distribution in specialised drug treatment centres (CAARUDs), harm reduction facilities (CSAPAs), automatic distribution machines and postal Needle and Syringe exchange Programme.

- 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. Between 2016 and 2019, around 21 000 naloxone kits were distributed.

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). In 2018, 573 deaths were registered in the specific registers (464 in DRAMES added to the 109 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 2018, opioids were implicated in 76% of the deaths reported in the DRAMES survey. Opioid substitution medications account for 43% of deaths: methadone is involved in 35% of deaths and buprenorphine in 8% of cases. Other opioid drugs (especially morphine) are involved in 10% of deaths, heroin in 28% and cocaine in 26% of fatal drug-related overdoses. The percentage of deaths involving cannabis was 4% (only deaths for which a cardiovascular pathology has been identified), 8% for amphetamines and MDMA and 2% for new psychoactive substances (NPS). In 31% of deaths, several substances were involved.

Ten deaths were directly caused by new psychoactive substances and involved the following molecules: 5-MeO-DALT (implicated for the first time in 2018) as well as 3-MMC, 4-MEC, 5-APB, ocfentanil, ethylphenidate.

In 2018, eight deaths related to GHB were reported. As a new development, Pregabalin was involved in 6 deaths (always simultaneously) in 2018, whereas in previous years it was involved in one death each year at most.

In 83% of cases, deaths directly related to drugs identified in DRAMES concerned men. In 2018, the average age of death was 37.5 years old (37.1 years old for women and 37.6 years old for men), down 1.4 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) and the addictovigilance network, 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.) to disseminate and forward to all partners.

In contrast to the previous year, few deaths or serious intoxications were reported to the OFDT and the national partners at an early stage. (see T.4 Additional information). In particular, it is possible to note the absence of serious signals around synthetic opioids.

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

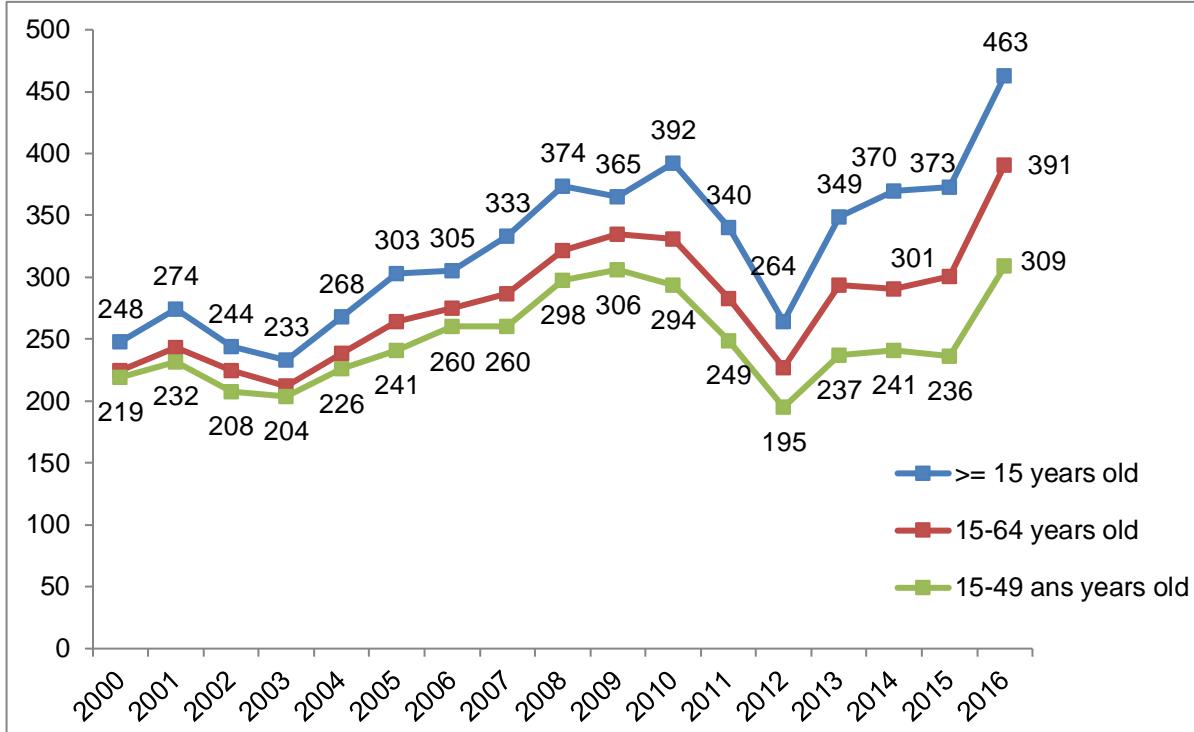
Short term trends

Direct drug-related deaths (DRD)

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 2012 and 2018, opioid substitution medications were the main substances implicated in overdose deaths ahead of heroin. The proportion of deaths related to heroin (28%) is up very slightly while that related to methadone (35%) is down very slightly in 2018. 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 2015) (Néfau 2017).

The proportion of deaths related to licit opioids (excluding opioid substitution medications) was downward (10%) in 2018. Morphine remained the most common cause (21 cases), with the number of tramadol-related deaths increasing (15 cases), while the number of fentanyl-related deaths (4 cases) was stable.

The proportion of deaths where cocaine was involved (whether hydrochloride or the base form) was stable (26%) in 2018, after a sharp increase between 2013 and 2017. 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 over 2012-2018. In 2018, 45 experts from 28 structures covering 70% of the French territory reported cases.

Table: Breakdown of drug-related deaths by substance(s) involved*, alone or in combination, from 2012 to 2018**

	2012		2013		2014		2015		2016		2017		2018	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Opioid substitution medications	187	60	153	54	134	55	140	41	188	46	195	45	198	43
- of which methadone	140	45	112	39	108	44	105	31	148	36	160	37	163	35
- of which buprenorphine	47	15	45	16	28	12	36	10	42	10	35	8	35	8
Other opioid medications (non-OST)	36	12	33	12	23	9	31	9	58	14	57	13	46	10
Heroin	47	15	57	20	62	26	103	30	106	26	109	25	130	28
Cocaine	36	12	25	9	33	14	44	13	75	18	112	26	120	26
Other illicit substances	31	10	47	16	32	13	74	22	64	16	65	15	66	14
- of which cannabis	15	5	31	11	19	8	36	10	30	7	28	6	20	4
- of which amphetamines and MDMA/ecstasy	15	5	14	5	9	4	27	8	22	5	27	6	37	8
- of which NPS			1		5	2	15	4	14	3	12	3	10	2
Others (psychoactive medicines, etc.)	9	3	43	15	36	15	55	16	63	16	33	8	62	13
TOTAL	310		285		243		343		406		432		464	
Number of participating toxicological experts	41		32		38		45		48		51		45	

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)

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 109 analgesia-related deaths (excluding deaths involving salicylic acid and paracetamol) in 2018. The medications in question were tramadol (45% of deaths), morphine (29% of deaths), oxycodone (17%), codeine (13%), and fentanyl (4%). Mean age at the time of death was 50.5 years, up 8 years since 2015. 56% of deaths occurred in women, whereas in previous years they were in the minority.

In order to limit the misuse of tramadol, the maximum prescription period for analgesic drugs containing tramadol has been limited to 3 months since April 2020, instead of 12 months previously. Beyond 3 months, continuation of tramadol therapy will require a new prescription. ([Arrêté du 13 janvier 2020 fixant la durée de prescription des médicaments à base de tramadol administrés par voie orale](#)).

The Société française de toxicologie analytique (SFTA) (French Analytical Toxicology Society) has updated in 2020 its guidelines for toxicology analyses in deaths involving NPS (SFTA 2020). 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.

Several case studies reporting deaths related to NPS (4-MEC, 3MMC, carfentanil, ocfentanil, Meo_PCP) have been published (Allibe *et al.* 2019; Ameline *et al.* 2019a; Ameline *et al.* 2019b; Gaulier *et al.* 2019; Grossenbacher *et al.* 2019).

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)

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 2019).

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

The prevalence of chronic hepatitis C (HCV RNA positive) among people who have experimented with intravenous drugs is estimated to be 12.1% (95% CI: 2.9-38.4) according to the 2016 Barotest, a telephone survey conducted with a random sample in the general metropolitan population coupled with a virological component based on a self-sampling of blood deposited on blotting paper taken at home. (cf T5. Sources) (Saboni *et al.* 2019).

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 (OFDT 2018).

Trends

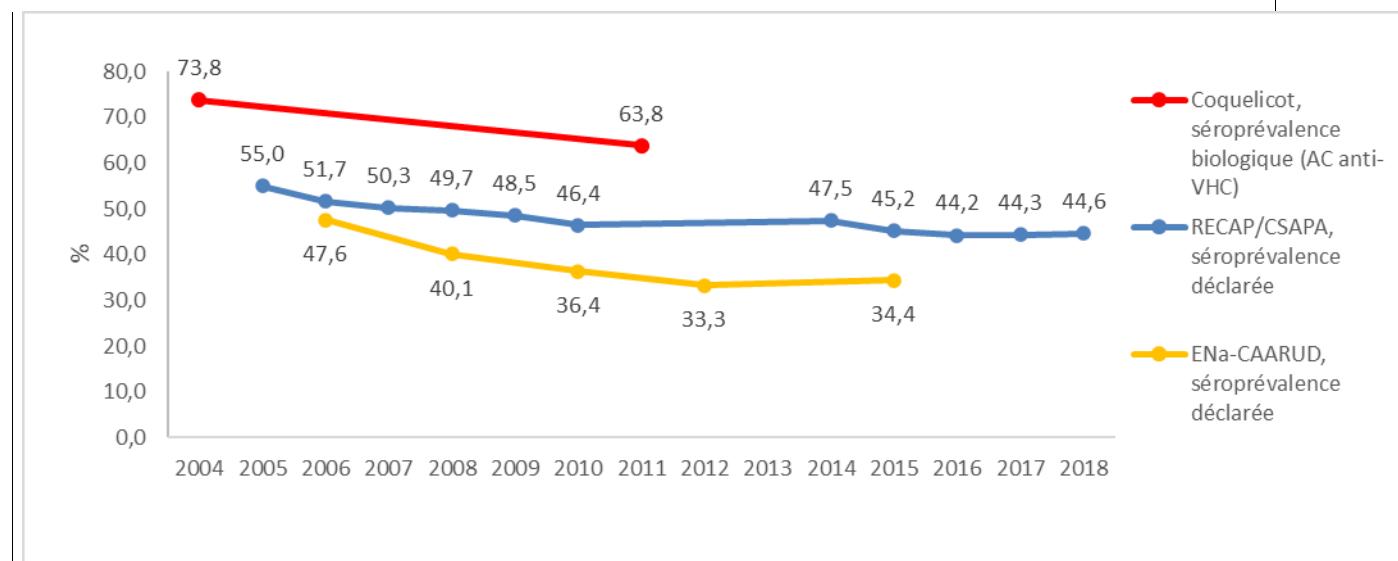
Prevalence and incidence of infections

In 2011, the biological seroprevalence of HCV (AC anti-VHC) 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, according to the Coquelicot-ANRS survey (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 2018 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; OFDT 2018, 2019a; 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 2018, 67 injecting drug users (IDU) were newly diagnosed as being HIV seropositive i.e. 1.1% of all new diagnoses (vs 66 cases in 2017). 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 (See section T5.1 on sources at the end of this document). Persons with a high viral load ($\geq 100\,000$ copies of the virus/ml) at the time of discovery account for 32% of IDU discoveries. The proportion of advanced diagnosis (CD 4 < 200 or AIDS stage) is high among IDUs (55% versus 29% among all findings). The share of anti-HCV anti body carriers is 82%, the share of HBV (HbsAg) co-infections among IDUs at the time of discovery of HIV seropositivity is 2%, and the share of co-infections with a bacterial sexually transmitted infection (syphilis, gonococcal or chlamydia trachomatis infection) is 4%. Among IDUs discovering their HIV seropositivity in 2018, 59% were born abroad, mainly in Europe. Between 2013 and 2018, the number of discoveries of HIV seropositivity among IDUs born in France decreased by 27%.

The share of IDU with AIDS was 4.7% in 2018 (46 cases). Finally, IDU account for 17% of all AIDS deaths (Lot *et al.* 2019; Lot and Lydié 2019; Santé publique France 2018, 2019).

No compulsory notification systems for diagnoses of chronic hepatitis C exist in France. With regard to acute hepatitis B (for which mandatory reporting began in 2003), the completeness of reporting has been estimated at 9-15% in 2010, 24% in 2013 and 27% in 2016. Over the period 2003-2018, 1 788 cases of acute hepatitis B were reported. Since 2007, the annual number of reported cases has decreased to 58 cases in 2018. The number of diagnosed acute hepatitis B cases is estimated taking into account underreporting at 257 (95% confidence interval, 95% CI: [225-290]) in 2018, i.e. a rate of 0.39 [0.34-0.44] per 100 000 inhabitants, not significantly different from that estimated for 2013 (0.44/100 000 [0.39-0.50]) (Laporal *et al.* 2019). Among the cases declared between 2003 and 2018, 4% of persons reported drug use in the 6 months prior to diagnosis (Vaux *et al.* 2019).

Trends

The annual number of new seropositive diagnoses among IDUs decreased by 36% between 2010 and 2018.

The share of IDUs among new AIDS cases decreased by 63% between 2010 and 2018. 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 2019b). 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. While the share of IDUs among all AIDS deaths remains high, it has decreased from 31% in 2013 to 17% in 2018. (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 comorbidity (suggested title: *Other drug-related health harms*)

The national health alert system for the consumption of psychoactive products was mobilised in two specific areas during the year.

The misuse of nitrous oxide resulted in 10 cases of severe neurological damage in 2019, concentrated between September and October 2019. In the period 2018 and 2019, 47 cases were reported to addictovigilance centres, including 37 serious cases classified as such due to the presence of one or more of the following characteristics: clinical consequences, abuse, dependence, consumption of very high doses (up to several hundred cartridges per day), daily use. In 60% of these severe cases, neurological complications were found. According to the data provided by the ANSM and the addictovigilance network, the clinical symptoms of these cases were paresthesias. Damage to the spinal cord has been found, sometimes in the form of combined spinal cord sclerosis. An expert report is to be drawn up by the ANSM and a legislative reflection is underway to regulate the use of this product, present in whipped cream dispenser cartridges and dry air aerosols, as best as possible (see WB Legal framework).

Cases of "EVALI" (e-cigarette or vaping, product use associated lung injury) pneumonia in the United States in the summer of 2019 have prompted a tightened national surveillance system. Only 5 cases have been identified, 3 of which predate the American alert and none of which resulted in death. Two other surveys have been set up, the results of which will not be known until later. These are VIGIVAPE, conducted by the ANSES and the anti-poison centres (prospective survey between July 2019 and December 2020) and VAPOTOX, conducted by

the CEIP of Nancy to better document any adverse event related to vaping in the Grand-Est region.

In light of the known elements concerning the American cases, they seem to have been caused by the use of vitamin E acetate as a cutting agent in e-liquids, in distribution channels which primarily concern this region of the world.

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 2019b, c). 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, ELSA¹, 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 n°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 Commission on Narcotic Drugs and Psychotropic Substances, meeting on 11 October 2018, proposed measures to reduce the number of overdoses (ANSM 2018). The priority measures are:

- to homogenise access to care throughout the country;
- to make all forms of ready-to-use naloxone widely available;
- to update the guidelines issued by the *Fédération française d'addictologie* [French Federation of Addictology] in 2004 on therapeutic strategies for people dependent on opiates (therapeutic strategy of substitution treatments);
- to inform about the risks of overdoses with opioid substitution medications by disseminating the already existing information leaflets;
- to increase the number of health care professionals involved in the treatment of opioid-dependent patients;

¹ hospital-based addiction liaison and treatment team

- to establish a system of legal protection for persons who offer assistance to another person in danger after using illicit substances, so that the person providing assistance does not hesitate to call for help through fear of prosecution

The 2018-2022 National Plan for Mobilisation against 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)

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 Stérifox® units², 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 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 2018, medico-social harm reduction facilities (CAARUD and CSAPA) covered the majority of the French territory: 7 departments (out of a total of 101) do not have a CAARUD, and all departments have CSAPA. There are no centres in rural areas and only three are located in a small urban district (less than 20 000 inhabitants). Since 2011, there has been a remote syringe exchange programme, which aims to meet the needs of users who are far from the medical-social system. In 2018, just over 447 000 syringes were delivered under this scheme (see below). The remote monitoring of users, implemented during the period of lockdown related to the COVID-19 pandemic has in fact broaden the geographical radius of intervention of the CSAPAs and the CAARUDs. In the departments that have them, the facilities are highly concentrated in large urban areas. More than half (51% of CAARUDs, or 75 centres in 2018) are located in a municipality of at least 200 000 inhabitants. The strong presence observed of harm reduction facilities in the major urban areas is notably linked to the relatively high number of CAARUDs located in Paris or in the greater Paris region (5% of the total number of CAARUDs identified at a national level).

CAARUD harm reduction activities

In 2018, 147 CAARUDs were registered in France, including six located in French overseas departments. 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). The funds are mainly used to pay non-volunteer staff, to rent equipment and infrastructure, and to purchase educational and harm reduction materials distributed to users. Subsidies paid to structures located in mainland France in 2018 represent approximately €59.3 million (this amount is slightly underestimated as data collection is not exhaustive). The harm reduction actions carried out by the facilities mobilised a little over 900 FTE (full-time equivalents) in 2018, of which 98 jobs were filled on a voluntary basis. Most of them were recruited by harm reduction facilities operating in the French territory, with the FTEs mobilised by the CAARUDs located in the overseas departments and regions representing only a marginal part. Nearly half of the number of staff of these organisations (46% of FTEs in France and 38% in the overseas departments and regions) are prevention educators and workers. The positions occupied by nursing staff and management are in second place for facilities in metropolitan

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.

France. Secretarial and logistics posts account for 17% of FTEs in CAARUDs located overseas. The presence of medical staff, psychologists and social workers remains marginal (less than 5% of the workforce) as well as that of peer users. It should be noted that the latter are mobilised by organisations operating in metropolitan France, whereas they are totally absent from organisations located in the overseas territories.

Most of the reception is done in a fixed location, but sometimes the teams intervene with drug users exclusively by means of a truck or bus (a mobile unit). More than a third of the CAARUDs are equipped with both a local and a mobile unit. In 2018, the annual CAARUD new outpatient admissions were estimated at around 90 000 individuals, and 5 000 of them were seen in structures located in the overseas territories. Slightly more than 48 000 users have visited the fixed reception areas of CAARUDs and approximately 16 000 people have received follow-up care by teams in mobile units. In terms of new users in 2018, there were nearly 22 000 people, 75% of whom were in fixed reception areas and 25% in mobile units, i.e. approximately 16 500 and 4 900 people respectively.

Female clients are in the minority, with women accounting for 31% of visitors to CAARUD premises, and 35% of clients followed up by mobile units, i.e. 15 200 and 4 900 women, respectively.

The CAARUD main actions include creating links with the most vulnerable drug users, access to essential services, health care and social rights. Hence, the most common actions involved maintaining social links or counselling (43%), harm reduction measures related to drug use and sexuality (25% of actions carried out) and responding to the most basic needs (basic hygiene) corresponding to 14% of total actions. Actions relating to care and access to services are observed to a relatively lesser extent (8% 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 (2%). In 2018, the procedures least practised are those relating to access to and search for training and employment, and those relating to job retention and training (0.8%).

The intervention processes are fairly similar. In 2018, all CAARUDs offered individual support and guidance towards the services or systems best suited to the needs of users. Individual interviews are by far the most common practice (100% of the structures). Nearly nine out of ten facilities (89% of CAARUDs) offered small group interventions in the form of thematic workshops (i.e. harm reduction and alcohol, safer injections, theatre, relaxation, painting, chess, sewing, gardening, socio-aesthetic workshops, football for example). 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 (Díaz Gómez à paraître).

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 1^{er} 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 1^{er} 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.

In 2019, the HAS [French National Authority for Health] issued an opinion that the effectiveness of the universal hepatitis C screening strategy (screening of the entire population aged 18 to 80 years) compared to screening targeting those most at risk of exposure to HCV has not been demonstrated (HAS 2019a).

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 load 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 2017, CAARUDs contribution to the provision of harm reduction material is estimated at 8.26 million syringes. There were 8.06 million syringes in 2018 (see table below).

*Table: Distribution of sterile prevention material by the CAARUD network in 2017 and 2018**

Injection equipment	All of France 2017	All of France 2018
Single syringes	5 518 020	5 508 411
Syringes in kits: automatic distribution machines	405 886	369 414
Syringes in kits: teams	1 093 866	952 176
Syringes in kits: pharmacy network	1 247 608	1 235 192
Total number of syringes distributed	8 265 380	8 065 193

Needles	277 764	228 102
sterile mixing containers	2 798 979	3 573 626
Sterile filters	1 623 651	1 547 972
Water (5-ml vials)	3 174 328	3 031 886
Alcohol pads	3 242 268	3 016 010
Tourniquets	18 769	27 890
Citric/ascorbic acid	23 908	58 589
<i>Total number of kits (automatic distribution machines, teams, pharmacy network)</i>	<i>1 373 680</i>	<i>1 278 391</i>
Snorting equipment		
Small paper pads "roule ta paille"	621 965	607 950
Normal saline solution	198 535	220 481
Other snorting equipment	46 470	36 545
<i>of which snorting kit</i>	<i>1 615</i>	<i>19</i>
<i>of which strawbags</i>	<i>857</i>	<i>123</i>
<i>of which creams</i>	<i>39 613</i>	<i>5 494</i>
Inhalation equipment		
Measures	203 968	251 783
Tips	156 153	274 666
razor blades	9 730	15 939
Crack filters	231 750	468 546
Inhalation kits	40 094	49 234
Healing cream	213 617	143 884
Aluminium foils	494 242	694 821
STI prevention material		
Male condoms	761 290	733 134
Female condoms	29 304	26 714
Lubricant gel	270 077	297 747
Other prevention materials		
Alcohol breath tests	61 633	68 429
Ear plugs	46 232	31 394
Brochures, flyers (pharmacy network)	79 696	43 827
Brochures, flyers (CAARUD teams)	139 459	162 795
Pads to disinfect the skin/ dry wipes	285 014	382 490
Sterile Drapes	12 352	7 393
Naloxone	0	90
SEP (Syringe Exchange Programme) and DASRI (waste from care activities with infectious risk) activities		
Tokens (pharmacies)	13 087	13 128
Tokens (CAARUD teams)	65 196	47 503
Used syringes recovered by CAARUD teams	4 719 890	4 147 373
Syringes recovered via collectors	7 153 465	14 015 018
* 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.		
Source: CAARUD 2017-2018 activity reports (DGS – processed by the OFDT)		

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 2017, the CSAPA network distributed overall approximately 565 000 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. The number of syringes sold in community pharmacies in *Stéribox®* form decreased from 4.45 million in 2011 to 3.25 million in 2017, then 3.1 million in 2018 and more recently, to 2.95 million in 2019 i.e. drop in sales by a third. (Siamois data, GERS, processed by OFDT). In 2016, the year for which the global distribution of syringes was estimated, sales of *Stéribox®* amounted to 3.35 million.

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 kits⁵ 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. Syringe distribution was estimated at approximately 450 000 units in 2017 and just over 415 000 in 2018.

b.4) Postal syringe exchange programme (SEP)

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 2018, a little more than 447 000 syringes were dispensed as part of the postal needle and syringe exchange programme (SEP). There were nearly 356 000 in 2017 (Association SAFE 2019). Slightly over two thousand users have benefited from the programme since it was introduced in 2011 (representing 2 400 users). 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,... (Association SAFE 2019).

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 véneneuses 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).

In total, between 2016 and 2019, 21 050 naloxone kits were delivered (18 409 Nalscue® kits and 2 641 Prenoxad® kits). Of these kits, 88% were delivered in CSAPA and in CSAPA-CAARUD, 9% in CAARUD and 3% in distributing pharmacies.

In 2020, the Nyxoid® speciality (naloxone 1.8 mg, solution for nasal spray in a single-dose container) received a positive opinion from HAS (the National authority for health) for reimbursement as emergency treatment for known or suspected opioid overdoses manifested by respiratory and/or central nervous system depression in both non-medical and healthcare settings. The medical service rendered is significant, while the improvement in the medical service rendered is considered minor as for Nalscue® (HAS 2020).

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 09:30 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).

Since October 2019, the DCR has extended its morning hours. It now opens at 9:30 am as opposed to 1:30 pm before.

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 2018, the room admitted 375 different users (vs 271 in 2017) in the space for using (79% men, 21% women and 0.5% transgender people), with 9 559 drug use episodes. 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 (mix of heroin and cocaine). Routes of administration are injection (in 82% of cases), ahead of smoking (14 %), snorting (3 %) and inhalation. Five overdoses required the intervention of the rescue services and led to 3 transfers to the hospital. (Association Ithaque 2017; Bader 2018) (unpublished data from the Ithaque association). These overdoses did not result in any deaths.

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 Plan for Mobilisation against 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 2020 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 (Dessauze *et al.* 2019a). Among the beneficiaries who were reimbursed for a substitution medication during the decade 2008-2017 (a proxy for the population who currently or in the past injected drugs), 8 714 initiated DAA treatment between their appearance in 2014 and 2017, i.e. 15% of all patients treated with these new drugs in the general population. The annual number of patients treated with OST increased steadily over the period, from 1 440 in 2014 to 3 063 in 2017. The overwhelming majority of OST patients who started DAA treatment were male (81%). Half of these patients were at least 50 years old (Dessauze *et al.* 2019b).

According to the results of the ANRS-Fantasio study, women who were dependent on opioids were less likely than men to receive treatment for hepatitis C (Rojas Rojas *et al.* 2019).

According to 2014 estimates, 12 100 injecting drug users (current or former) are living with HIV in France, 98% of whom have been diagnosed, 91% are being treated with antiretroviral drugs and 88% have a controlled viral load (ECDC 2018).

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.

l) Drug analysis as a harm reduction measure

Drug testing allows users of psychoactive substances to learn about the composition of their product by having it analysed. This service is used as a risk reduction measure to enable people to become informed, make choices based on reliable information and thus better protect and improve their health.

Based on its experience, the NGO *Médecins du Monde* [Doctors of the World] has developed an educational reference document presenting the drug analysis scheme as a whole and describing the procedure for collecting and reporting results from users, as well as a technical reference document detailing the process of analysis by thin layer chromatography (Bichet et al. 2019).

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.

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)

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 Ministry of Solidarity and Health has developed a list of prevention materials for harm reduction services that provides knowledge on risk reduction tools that are known to be effective and acceptable (Direction générale de la santé 2020).

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.)

At the beginning of the lockdown period related to the COVID-19 epidemic (which lasted from 17 March 2020 to 11 May 2020), the Ministry of Solidarity and Health made recommendations concerning the continuity of activities in CSAPAs and in CAARUDs (https://solidarites-sante.gouv.fr/IMG/pdf/covid-19-fiche_structures_prevention-pec.pdf). Whenever possible, remote activity was favoured. The CSAPAs maintained individual medical, paramedical and psychological consultations and care activities, prescription and delivery of opioid substitution treatment. The distribution of harm reduction materials has been maintained by CAARUDs and CSAPAs. Also, the CAARUDs continued their patrolling activities towards precarious and marginalised audiences and the activity of the supervised drug consumption rooms was maintained. At the end of the lockdown period, new guidelines were issued for a gradual resumption of organisational operations (<https://splf.fr/wp-content/uploads/2020/05/Ministere-de-la-sante-Pour-une-reprise-progressive-des-activites-des-structures-de-prevention-en-sante-et-de-prise-en-charge-qui-accueil-du-public-en-poste-confinement-13-05-20.pdf>). In addition to the general health measures to be adopted and the organisation of premises and activities, these guidelines concern the priority activities to be resumed in the presence of people and specific points of attention (the reception of new users, the identification of psychological disorders and social difficulties related to confinement, the systematic question of violence and infectious risks, the risks related to the resumption of consumption, users' access to naloxone and finally the resumption of the link with those "out of sight").

In addition, in order to avoid any interruption of treatment prejudicial to the patient's health, the [order of 23 March 2020](#), completed on 18 May 2020 ([order prescribing the measures for the organisation and operation of the health system necessary to deal with the COVID-19 epidemic in the context of the state of health emergency](#)), allowed distributing pharmacists to renew prescriptions for opioid substitution therapy. (See T4.2 of the Treatment workbook).

The Ministry of Solidarity and Health has also put posters and fact sheets online on ready-to-use naloxone kits to promote access to it during the lockdown period. One sheet is for the public, the other is for professionals: <https://solidarites-sante.gouv.fr/prevention-en->

[sante/addictions/article/surdoses-overdose-d-opioides-la-naloxone-est-utilisable-par-tous-et-peut-sauver](https://www.santeaddictions.fr/article/surdoses-overdose-d-opioides-la-naloxone-est-utilisable-par-tous-et-peut-sauver).

During the period of lockdown, the TREND scheme also documented the commitment of professionals faced with multiple difficulties in caring for people in situations of huge insecurity. Many CAARUDs have developed alternative delivery methods, such as home delivery or "drive" delivery with extended time slots. The CAARUDs have set up or reinforced patrols, some have also provided food aid and hotel accommodation initiatives. The remote harm reduction scheme has experienced a significant increase in activity during the lockdown. More than 100 new users were added to the system in March 2020, compared to an average of 33 per month in 2019, the highest monthly increase in the active files since the programme was created. In the first 19 days of April, 59 new users joined the system. Nearly 62 864 syringes were provided (compared to 37 186 in February 2020) (Gérôme and Gandilhon 2020a, b). On the other hand, in pharmacies, sales of Steribox kits are down (-6.6%) in March 2020 compared to March 2019, following the same trend as that observed over the last 12 months (-4.3%) (GERS-Siamois data, processed by OFDT).

With regard to atypical health signals, reported at an early stage on a national level, we note the persistence of non-fatal intoxication, or death, following consumption of cathinones (3-MMC and 4-MEC) in a context of relative violence that required police intervention (a total of 11 signals, with 2 deaths, 3 non-fatal intoxications and 6 cases of driving under influence).

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

In France, there are currently three sources that list fatal overdoses:

1. **The national statistics on the medical causes of death (CépiDc-INSERM).**

Since 1968, this registry has been listing information from death certificates on all deaths in the past year. Fatal overdoses are those for which the death certificate mentions codes from the International Classification of Diseases (ICD-10) that are on the list of codes established by the EMCDDA (selection B : [http://www.emcdda.europa.eu/publications/methods/drд-overview](http://www.emcdda.europa.eu/publications/methods/drد-overview) [accessed 29/07/2019]). Without going into further detail here, this is a group of codes mentioning the use of an illegal substance or certain medications. Some fatal overdoses are nevertheless coded under "deaths with poorly defined causes" and therefore are not registered. Furthermore, the substances responsible for death are poorly detailed in this source, since the most frequently seen wording is that of polydrug use without any further specifications. These data only become available two years after they are recorded. The underestimation of overdose deaths has been estimated at 30% among 15-49 year olds in 2007 (Janssen 2011).

National registry of causes of death

Centre for epidemiology of the medical causes of death (CépiDc) of the National institute for health and medical research (INSERM)

Since 1968, the INSERM'S CépiDC department has been recording all deaths observed on French territory. The information on the causes of these deaths comes from the death certificate (paper or, since 2007, electronic) completed by the physician recording the death. They are coded by the INSERM following the 10th revision of the International Classification of Diseases (ICD 10).

This system enables annual, national statistics on medical causes of death to be established in cooperation with the French National Institute for Statistics and Economic Studies (INSEE), which oversees National Directory for the Identification of Natural Persons (RNIPP) containing all information from birth, marriage and death records. In some cases, information pertaining to the causes of death that are to undergo forensic investigation is not always submitted to the INSERM. These deaths remain classified as cause unknown, generating an under-representation of certain causes in the statistics (especially violent deaths and fatal overdoses).

2. **The information system known as DRAMES (Drug and Substance Abuse-related Deaths).** This information system records deaths that involved legal proceedings and a request for a toxicology analysis and/or autopsy. Volunteer toxicological analysts report these cases throughout the French territory. Analyses are performed upon the request of the public prosecutor's office. The definition of overdose used is very similar to the definition accepted by the EMCDDA (illegal substances and opioid substitution treatments) but do not include suicidal deaths. Contrary to the preceding source, DRAMES is not exhaustive. First of all, DRAMES does not cover all toxicology laboratories, and secondly, the system only lists deaths for which the judicial system requested a toxicological analysis, and such requests are not systematic. Therefore,

DRAMES data are mainly useful in determining a breakdown of fatal overdoses according to the substance that caused them.

DRAMES: Drug and Substance Abuse-related Deaths

Network of the Regional Abuse and Dependence Monitoring Centres (CEIP-A) and French National Agency for Medicines and Health Products Safety (ANSM)

Implemented in 2002, this information system uses a continuous method for collecting data in mainland France and was set up in order to obtain the most exhaustive data possible on deaths occurring from use of psychoactive substances in the context of drug abuse or addiction. The system also aims to describe the circumstances under which the body was discovered, the level of abuse at the moment of death and the results of the autopsy, as well as to identify and quantity the substances involved, through blood testing.

Forty-five experts performed toxicological analyses within a forensic scope in the 2018 edition of the survey.

3. DTA: Analgesia-poisoning deaths

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

Introduced in 2013, this survey aims to collect cases of death related to analgesic drug use, to identify the medications involved, evaluate their hazards and estimate changes in the number of deaths. This survey is based on the prospective collection of cases of analgesia-related deaths, reported by expert toxicologists carrying out toxicology analyses requested by the courts to investigate causes of death. For these cases to be included, death must be attributed to one of the following substances: acetylsalicylic acid, buprenorphine, codeine, dextropropoxyphene, dihydrocodeine, fentanyl, hydromorphone, ketamine, morphine, nalbuphine, nefopam, oxycodone, paracetamol, pethidine, pregabalin or tramadol. Deaths occurring in a context of substance abuse and drug addiction are excluded, and those occurring in the context of suicide are included, in contrast to the DRAMES survey.

Twenty-one toxicological experts performed forensic analyses for the 2015 edition of the survey. Cases included in the APD survey (excluding those involving salicylic acid and paracetamol) combined with DRAMES cases correspond to EMCDDA selection B deaths.

The number of AIDS deaths related to intravenous drug use can be estimated using the national HIV/AIDS monitoring database coordinated by *Santé publique France*.

Drug use-related hospital emergency presentations (Emergencies)

Oscour® network: Coordinated hospital emergency presentation monitoring network *Santé publique France, SpF (French Public Health Agency)*

After its creation in 2004, the hospital emergency network has gradually expanded. In 2015, 632 out of the 770 existing emergency units were part of the monitoring network, thus covering 86% of hospital emergency presentations in France. There is at least one emergency room in the OSCOUR® network for each French region. Coverage varies according to different regions.

Data collection is based on the direct extraction, without generating extra work for emergency room professionals, of anonymous information, taken from the patient's electronic medical record compiled during their visit to the emergency room. Sociodemographic (gender, age, department of abode), administrative and medical (main diagnosis, associated diagnoses, degree of severity, patient's destination after visiting the emergency room) variables are thus collected.

The OFDT analysed data from 2008 to 2015 on drug-related poisoning for the purposes of surveillance and annual monitoring.

Presentations to the emergency room in connection with drug use-related poisoning cover main diagnoses with EMCDDA selection B ICD codes (F11, F12, F14, F15, F16, F19, X42, X62, Y12, T40, T 43.6).

Euro-DEN and Euro-DEN plus: European Drug Emergencies Network

Euro-DEN was developed in 2013 at 16 sentinel sites located in 11 European countries. This project was initially funded by the European Commission Department for Justice. The network then expanded to 20 sentinel sites in 14 countries and is now known as Euro-DEN plus. It is currently funded by EMCDDA. In France, the emergency room of the Lariboisière hospital in Paris has been a part of this network since 2013.

The network of sentinel sites automatically collect data on harm (acute toxicity) associated with drug use. The cases included comprise presentations to an emergency room for symptoms and/or signs of acute intoxication induced by illegal or recreational drug use, NPS or misuse of medications procured with or without a prescription. ER presentations due to alcohol poisoning only are excluded.

The data collected include demographic characteristics (age, gender, date and time of the presentation to the emergency room, date and time of the hospital discharge, place of abode), and information on the substance taken, together with the place and time of use. Lastly, data on clinical examination, type of treatment received, the patient's destination after the ER presentation and, where appropriate, death in hospital are collected.

Harm reduction

ASA-CAARUD: National analysis of the CAARUD standardised annual activity reports *French Monitoring Centre for Drugs and Drug Addiction (OFDT) / National Health Directorate (DGS)*

Each year, the facilities send the National Health Directorate (DGS) and Regional Health Agencies (ARS) a standard activity report; these are then sent to the OFDT for analysis. The data collected make it possible to monitor the activity of the scheme since 2008. These data shed light on issues relating to geographical coverage, the allocated resources and access to CAARUDs. The information collected and analysed by the OFDT also enables the characteristics of the populations visiting harm reduction facilities and the activities of the professionals involved to be examined. Lastly, the ASA-CAARUD questionnaire offered to the facilities aims to document the distribution of injection and snorting materials, together with harm reduction resources for inhalation and the prevention of sexually transmitted infections. The questionnaire is based on a shared approach, initiated by the French Association for Drug Use-related Harm Reduction (AFR), in partnership with the OFDT and the health authorities.

SIAMOIS: System of information on the accessibility of injection equipment and substitution products

Group for the Production and Elaboration of Statistics (GERS)

This database was designed in 1996 to follow trends in access to the sterile injection material available in pharmacies, and trends in opioid substitution medications at local level. No data are available from 2012 to 2015, but only from 2016.

VIH/sida and viral hepatitis (Hepatitis B and C)

Infectious diseases account for most of the somatic morbidity observed. Estimates of prevalence levels among drug users were based on data collected within the scope of various surveys:

- The reported prevalence of HIV, HBV and HCV are delivered since 2005 (Palle and Vaissade 2007), these prevalence numbers have been supplied by the RECAP scheme of patients seen in CSAPAs and by surveys of patients seen in low-threshold structures (CAARUDs), particularly ENa-CAARUD surveys.
- The biological prevalence of HIV and HCV, determined using blood samples, were collected from the Coquelicot survey (Jauffret-Roustide *et al.* 2009) conducted in 2004 and 2011.
- Estimates of the national incidence of AIDS, HIV infection and acute hepatitis B infection were also performed. AIDS case and AIDS death reporting, which has existed since the early 80s, has been mandatory since 1986. A new anonymous reporting measure implemented in 2003 following a circular issued by the National Health Directorate (DGS) [[Circulaire n°2003-60 du 10 février 2003](#)], made HIV-infection reporting obligatory as well. This system is accompanied by HIV virological monitoring. Reporting of acute hepatitis B infection has been required since 2004.

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.

Acute Hepatitis B Monitoring System

Santé publique France, SpF (French Public Health Agency)

In March 2003, it became mandatory in France to report acute hepatitis B cases. Like for HIV and AIDS, HBV-positive individuals are anonymised as soon as they are tested in a laboratory. The testing laboratories report all suspected acute hepatitis B cases to the prescribing physician, who, in the event of a past medical history of hepatitis B, makes a report to the inspecting physician of the relevant Regional Health Agency (ARS).

The collected data help describe the epidemiological profile of infected individuals and to estimate the incidence in France and any changes thereof. To do this, the data coming from reports are corrected for under-reporting, this underestimation being assessed at 85-91% in 2010. They also help assess the impact of the prevention policy by quantifying the spread of the hepatitis B virus.

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.

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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 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.

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.

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 2 001 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.

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.