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### ► [The primary prevention of hepatitis C among injecting drug users.](#)

**Advisory Council on the Misuse of Drugs.**

**[UK] Home Office, February 2009.**

To curb hepatitis C, UK government advisers call for substantial expansion of needle exchange provision so that a new set of equipment is available for every injection and for methadone programmes to provide access to injecting equipment and vice versa.

**Abstract** The [Advisory Council on the Misuse of Drugs](#) is appointed by the UK government to provide it with independent, expert advice on drug-related issues in the UK. The featured report drew on and was published concurrently with [public health guidance](#) on [needle and syringe programmes](#) from the UK's National Institute for Health and Clinical Excellence (NICE).

The featured report ended with the following conclusions and recommendations.

- About half the drug injectors in the UK are infected with hepatitis C. However, there is a greater than threefold difference between sites in the UK. Hepatitis C prevalence among injectors may have fallen during the early 1990s but increased from the mid 1990s. Infection among those who recently started injecting almost doubled from 1998 to 2007. The public health challenge now is to increase action and effective prevention to stem the upward rise. The report endorsed the [recommendations](#) from NICE and commended the [hepatitis C action plan](#) in Scotland which has already started the process of expanding HCV prevention.

**Recommendation 1** Local service planners need to review local needle and syringe services (and be supported in this work) in order to take steps to increase access and availability to sterile injecting equipment and to increase the proportion of injectors who receive [100% coverage](#) of sterile injecting equipment in relation to their injecting frequency.

- The strength of the evidence for the effectiveness of many interventions in reducing hepatitis C transmission among injectors is weaker than the report's authors expected. However, there is emerging epidemiological evidence (supported by preliminary UK studies) that the combination of opiate substitution therapy and needle and syringe programmes is the most effective way to reduce hepatitis C (and HIV) incidence among active injectors. Neither alone may be sufficient to prevent hepatitis C. A comprehensive

hepatitis C prevention and harm reduction service needs to ensure both are provided and working together, and that the focus is on reducing injecting frequency and duration.

**Recommendation 2** Local services need to provide a comprehensive intervention so that those offering opiate substitution therapy also provide access to sterile injecting equipment and those providing sterile injecting equipment facilitate entry into opiate substitution therapy.

- The frequency of hepatitis C testing by prisons, specialist drug agencies, and other agencies managing current injectors, has been poor. About half of injectors are unaware they are hepatitis C positive. This needs to change. Dried blood spot tests, which are non-invasive and easy to learn, provide part of the solution. Hepatitis C testing and knowledge of hepatitis C status provides an opportunity to initiate further health education advice and harm reduction interventions of benefit to the patient (such as managing alcohol use if infected), to other injectors and society (reducing injecting risk behaviour), and potentially to both patient and society (referral for hepatitis C treatment; see recommendation 7). Information on hepatitis C testing may also be used to improve local and national estimates of the numbers infected with hepatitis C.

**Recommendation 3** All services (especially specialist drug clinics, low threshold agencies, and prisons) in regular contact with injectors need to increase the frequency of hepatitis C diagnostic testing among their clients.

**Recommendation 4** Review workforce and training needs of needle and syringe programmes and other drug workers and if necessary develop further training in order to ensure that staff are competent and confident in providing hepatitis C and other blood-borne virus antibody testing.

**Recommendation 5** Establish a monitoring programme to measure success against recommendations 3 and 4 such as: the proportion of specific agency caseloads (including prisons, specialist drug clinics, and patients in opiate substitution therapy shared care) tested for hepatitis C and other blood-borne viruses, and the proportion of injectors tested anonymously who are unaware of their hepatitis C status.

- There is an urgent need for UK-based research on the effectiveness and cost-effectiveness of needle and syringe programmes, opiate substitution therapy, and other interventions to reduce hepatitis C incidence. **Primarily** better evidence is needed on the 'intervention effect' of opiate substitution therapy and needle and syringe programmes. This will enable researchers and modellers to provide service planners with clearer recommendations on optimal service provision in relation to their different epidemics. The expansion of services and development of novel techniques to estimate hepatitis C incidence provide an ideal opportunity to generate better evidence. Cost-effectiveness modelling suggests that hepatitis C treatment of active injectors could have both a primary (reducing hepatitis C transmission) and a secondary (preventing hepatitis C morbidity) prevention role. The models **suggest** that the combination of opiate substitution therapy, needle and syringe programmes and hepatitis C treatment will have the greatest impact on hepatitis C.

**Recommendation 6** Studies are required that directly test the effectiveness of opiate substitution therapy and needle and syringe programmes on reducing hepatitis C incidence (ie, that generate evidence on the intervention effect).

**Recommendation 7** A study is required to measure the re-infection rate of injectors who have been treated for hepatitis C and to evaluate the effectiveness of providing hepatitis C treatment to current injectors in order to reduce hepatitis C incidence.

- There has been much **innovation** of prevention initiatives in the UK. Innovation and development need continued support, but more attention needs to be given to evaluation and to modelling potential impact and cost-effectiveness. **Recent injectors** have an elevated risk of hepatitis C infection, but no reviews provide evidence on which interventions successfully target, and reduce hepatitis C incidence, among this population. People with a prison history have a greater risk of infection but we cannot explain fully why and have no good quality review-level evidence or UK research on the effectiveness of prison-based harm reduction interventions. Homelessness also increases the risk of hepatitis C infection.

**Recommendation 8** Evaluate whether new health education messages have changed the perception and views of injectors about the risk and inevitability of hepatitis C; and whether campaigns to teach and encourage injectors to use bleach to clean injecting equipment (when sterile equipment is not available) have resulted in safer re-use of equipment.

**Recommendation 9** Studies are required to determine why injectors with a prison history are at greater risk of hepatitis C, and to develop and trial appropriate harm reduction interventions within the prison service and in the community to reduce the risk.

**Recommendation 10** Develop and promote effective strategies to target and reduce hepatitis C risk among recent injectors.

**Recommendation 11** A study is required to investigate hepatitis C risk and prevalence among people who use performance- and image-enhancing drugs

- Compared to many other countries, the UK has a well developed public health surveillance system for measuring the prevalence of hepatitis C. Though there is a need to improve **some of the epidemiological evidence**, greater priority should be given to supporting and monitoring the impact of interventions to reduce hepatitis C infection.

**Recommendation 12** The public health surveillance of hepatitis C needs to be developed and extended so that it can monitor and provide evidence on the impact of interventions on hepatitis C risk; and if required the roles and responsibilities of public health scientists and public health agencies need to be extended in order to support the development and evaluation of hepatitis C interventions.

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