

Harms and harm reduction workbook

2021

France

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Table of contents

- T0. Summary**3
- T1. National profile and trends**5
 - T1.1. Drug-related deaths5
 - T1.2. Drug related acute emergencies9
 - T1.3. Drug related infectious diseases10
 - T1.4. Other drug-related health harms12
 - T1.5. Harm reduction interventions12
 - T1.6. Targeted interventions for other drug-related health harms24
 - T1.7. Quality assurance of harm reduction services25
- T2. Trends Not relevant in this section. Included above.**25
- T3. New developments**25
- T4. Additional information**26
- T5. Sources and methodology**27

T0. Summary

Please provide an abstract of this workbook (target: 1 000 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.

In 2019, 648 deaths were registered in the specific registers (503 in DRAMES added to the 145 deaths of DTA). Opioid substitution medications are, ahead of heroin, the main substances involved in overdose deaths. According to the specific overdose death register (DRAMES scheme), opiates were implicated in 77% of case: opioid substitution medications in 43% of cases and heroin in 29%. Cocaine was involved in 22% of deaths.

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.

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.

The declared prevalence of HIV and HCV is stable in harm reduction facilities (CAARUD). In specialised drug treatment centres (CSAPA), the declared prevalence of HIV remains stable, and there is a positive impact of the universal access to treatment strategy on the proportion of users declaring themselves to be HCV positive (see T.1.3.1).

- National profile and trends harm reduction

Harm reduction policy for drug users is the responsibility of the State (article L.3411-7 of the French Public Health Code - CSP - modified by article 41 of Law no. 2016-41 of 26 January 2016 on health system reform and aims to prevent health, psychological and social damage, the transmission of infections and death by overdose linked to the use of psychoactive substances or substances classified as narcotics.

The harm reduction system is based on local professionals (CSAPAs, CAARUDs, pharmacies, primary care centres and associations), on various prevention programmes and on HIV and hepatitis prevention strategies. The medico-social system (CSAPA, CAARUD) covers most of the country. Harm reduction measures include the distribution of prevention materials, distribution of naloxone, OST and drug consumption rooms, as well as drug testing as a tool for harm reduction (see T.5.3).

Currently, a ready-to-use Naloxone solution is marketed in France: the Prenoxad® intramuscular injectable solution kit with a pre-filled syringe (0.91mg/ml). By the end of 2021, a ready-to-use naloxone kit in the form of a nasal spray should be available in health establishments, CSAPAs, CAARUDs and in dispensing pharmacies.

Two drug consumption rooms (DCR) opened in Paris and Strasbourg in 2016 as part of an experiment. A scientific evaluation of the experiment, the report of which was published in May 2021, confirms the value of DCRs with a positive impact on the health of drug users, with a reduction in risky HIV and HCV transmission practices, non-fatal overdose risks, visits to the emergency services and complications at the point of injection, and an acceptable cost-effectiveness ratio evaluated over 10 years. The results of the evaluation make it possible to study the possibility of new establishments and the perpetuation of DCRs as a complementary risk reduction tool.

A sterile material distribution programme has been in place since 1987. At present, the organisation of the provision of syringes is based on four distribution methods: distribution by the CSAPAs and CAARUDs, sale of kits and sterile syringes in pharmacies, distribution of syringes via automatic machines and a postal syringe exchange programme. The latter makes it possible to improve accessibility by removing obstacles related to geographical distance, opening hours and confidentiality. CAARUDs play a key role in the distribution of sterile prevention materials. In 2019, CAARUDs distributed 8.25 million syringes (8.06 in 2018).

The prevention of HIV and hepatitis C infections is part of the national strategies used in France for the prevention of these infections, which aim in particular to increase screening and prevention for most-at-risk populations in order to achieve the objective of elimination by 2030 and 2025, respectively. The actions implemented focus in particular on strengthening local screening using rapid diagnostic orientation tests (RDT) in a combined approach to HIV, HCV and HBV and "outreach" screening methods. Since 2016, various measures have been put in place to facilitate access to direct-acting antiretroviral drugs (DAAs) for the treatment of hepatitis C: access to treatment regardless of the stage of fibrosis, changes in the methods used to initiate treatment, opening up the prescription of two DAAs to all doctors.

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 France, 3 complementary sources of data are used to describe fatal overdoses. These are the National registry of causes of death INSERM-CépiDc and the two specific registers DRAMES and DTA (cf. T5 sources and methodology).

The most recent data from the National registry of causes of death are from 2016. At that time, there were a total of 463 fatal overdoses, of which 309 were among 15–49-year-olds. The majority of these deaths (78%) occurred in males. The number of deaths is most probably underestimated as some overdose deaths are classified as “unknown cause” (see 2020 HHR workbook).

The specific registers, which are not exhaustive, report a total of 648 deaths for the year 2019: 503 deaths were recorded on the DRAMES register plus 145 deaths on the DTA register. According to the data on the DRAMES register, the majority of subjects whose death was directly linked to drugs were men (79%) and on average, were aged 38.7 years old (38.3 years old for men and 39.9 years old for women) (CEIP-A Grenoble 2021a).

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

In 2019, opioids were implicated (alone or in combination) in 77% of the deaths reported in the DRAMES register (CEIP-A Grenoble 2021a) (cf. T5 sources and methodology). Opioid substitution medications account for 43% of deaths: methadone is involved in 35% of deaths and buprenorphine in 9% of cases. Other opioid drugs (especially morphine) are involved in 10% of deaths and heroin in 29% of fatal drug-related overdoses.

The distribution of deaths according to the other illicit substances involved is as follows: cocaine 22%, cannabis 7%, amphetamines/MDMA 6% and new psychoactive substances (NPS) 1%. In total, 5 deaths were directly caused by NPS, including 2 molecules involved for the first time: diphenidine and 4-Fluoromethylphenidate. The other molecules involved are: 3-MMC and 4-MEC. In 27% of the deaths, several substances were involved.

As last year, few deaths or serious intoxications were reported to the OFDT and national partners at an early stage (see T.4 Additional information; and T.1.1.2 of the 2020 HHR workbook for the description of the national health alert system related to the use of psychoactive products). In particular, it is possible to note the absence of serious signals around synthetic opioids.

The number of pregabalin-related deaths is increasing in the two specific registers. The DRAMES register reported 6 pregabalin-related deaths in 2018 and 7 deaths in 2019, whereas prior to 2018, pregabalin was implicated in at most one death per year. There has also been an increase in the number of deaths involving pregabalin on the DTA register (see T5 sources and methodology): 5 deaths in 2019 compared to 2 in 2018. Since they were first recorded in the DRAMES register in 2013 and DTA register in 2014, a total of 28 deaths attributed to pregabalin have been reported (15 in DRAMES and 13 in DTA). For all deaths, apart from one death recorded on the DTA register, other substances were co-implicated. This context of poly-drug use is found in the observations of the TREND monitoring scheme (see section D, T.3.1 of the 2021 Drugs workbook). As shown in the OSIAP (CEIP-A de Toulouse 2021) survey, pregabalin was also the most frequently falsified prescription drug in 2019. Since 2013, pregabalin has been monitored by the Network of the Regional Abuse and Dependence Monitoring Centres in France. According to the report drawn up by this network in September 2020, (CEIP de Toulouse 2020) it has been observed that, since 2014, there has been an increase in cases of abuse, misuse and dependence, which has become more pronounced since 2018.

In order to limit the misuse of pregabalin, part of the narcotics regulation has been applied to pregabalin-based medicines since 24 May 2021: it can only be prescribed on a secure prescription and maximum prescription duration limited to 6 months ([order of 12 February 2021 applying part of the narcotics regulation to pregabalin-based medicines](#)) see T.3.1 of the 2021 legal framework workbook).

In its 2020 recommendations to conduct toxicological analyses in cases involving NPS, the French Society of Analytical Toxicology suggested including pregabalin in toxicological investigations.

Concerning the cases of deaths related to the use of analgesic drugs, according to the DTA 2019 survey (CEIP-A Grenoble 2021b), tramadol (43% of deaths), morphine (25% of deaths), codeine (22%) and oxycodone (16%) are still the main molecules involved in direct deaths. Fentanyl is involved in 3% of deaths. Compared to 2018, there has been an increase in codeine-related deaths (13% in 2018). The register reports a case of death by methadone in the context of analgesia for the first time.

*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)*

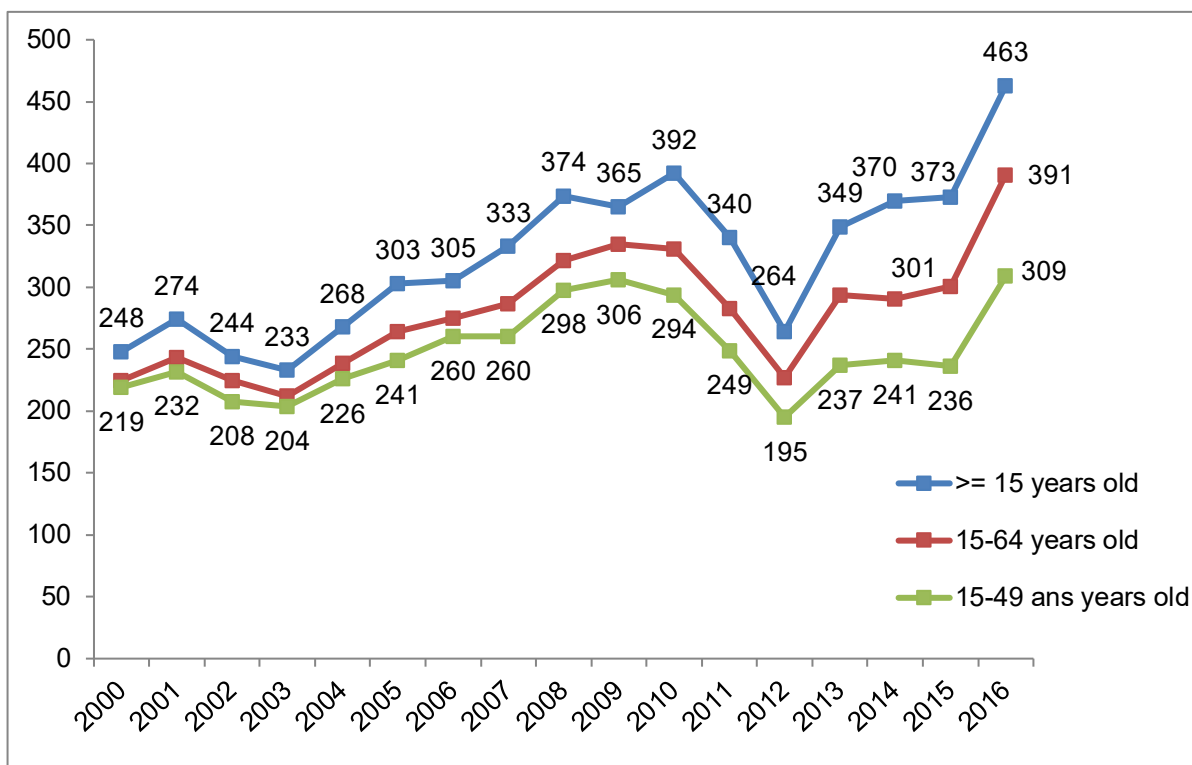
Mortality cohort studies

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

The most recent data from the National registry of causes of death are from 2016. 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 in under 50s between 2000 and 2015 appear to be strongly linked to the availability and purity of heroin (see 2020 HHR workbook; (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

DRAMES register (CEIP-A Grenoble 2021a): in 2019, opiates alone or in combination remain the main substances involved in overdose deaths: opioid substitution medications followed by heroin. With regard to opioid drugs other than opioid substitution medications, morphine remains the most frequently involved molecule. In 2019, there was a drop in the proportion of deaths linked to cocaine and NPS, while the proportion linked to cannabis increased (only deaths in which a cardiovascular pathology is known or revealed at autopsy are included for cannabis).

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 varies from year to year.

Table: Breakdown of drug-related deaths by substance(s) involved*, alone or in combination, from 2012 to 2019**

	2012		2013		2014		2015		2016		2017		2018		2019	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Opioid substitution medications	187	60	153	54	134	55	140	41	188	46	195	45	198	43	218	43
- of which methadone	140	45	112	39	108	44	105	31	148	36	160	37	163	35	178	35
- of which buprenorphine	47	15	45	16	28	12	36	10	42	10	35	8	35	8	46	9

Other opioid medications (non-OST)	36	12	33	12	23	9	31	9	58	14	57	13	46	10	48	10
Heroin	47	15	57	20	62	26	103	30	106	26	109	25	130	28	147	29
Cocaine	36	12	25	9	33	14	44	13	75	18	112	26	120	26	110	22
Other illicit substances	31	10	47	16	32	13	74	22	64	16	65	15	66	14	67	13
- of which cannabis	15	5	31	11	19	8	36	10	30	7	28	6	20	4	33	7
- of which amphetamines and MDMA/ecstasy	15	5	14	5	9	4	27	8	22	5	27	6	37	8	29	6
- of which NPS			1		5	2	15	4	14	3	12	3	10	2	5	1
Others (psychoactive medicines, etc.)	9	3	43	15	36	15	55	16	63	16	33	8	62	13	70	14
TOTAL	310		285		243		343		406		432		464		503	
Number of participating toxicological experts	41		32		38		45		48		51		45		46	

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.

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

DTA register (CEIP-A Grenoble 2021b): tramadol is the first molecule implicated in the deaths reported by the DTA register, ahead of morphine. Tramadol and morphine deaths remained stable in the period between 2016 and 2019, while oxycodone deaths increased significantly in 2017 before stabilising.

Distribution of deaths* according to the substances involved**

	2015	2016	2017	2018	2019
	%	%	%	%	%
Tramadol	34	44	46	46	43
Morphine	32	26	29	29	25
Codeine	27	19	18	13	22
Oxycodone	10	9,5	18	17	16

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.

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

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 ([Order of 13 January 2020 establishing the prescription period for orally administered tramadol-based medicines](#)).

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)

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 Oscore[®] 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 (*Santé publique France 2019b*). 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).

In 2020, the phenomenon of cannabis adulterated with synthetic cannabinoids (see T.1.1.5 of the 2021 'markets and crime' workbook and A T.1.2.4 of the 2021 "Drugs" workbook) led to the identification of 60 to 90 persons (including recourse to emergency services, medical consultations, and SINTES collections carried out by the CEIPs), according to a count made by cross-referencing the data obtained via SINTES, the ANSM and the Network of the Regional Abuse and Dependence Monitoring Centres between September 2020 and the end of April 2021.

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

According to the results of the ENa-CAARUD survey (see T5 sources and methodology), the number of drug users who reported having been tested for HCV at least once increased in 2019 to the level already observed in 2012 (87%). The number of drug users who reported having been tested for HIV at least once remained stable (91%). Of the lifetime injectors who have been tested at least once in their lives, 6% declared themselves to be HIV-positive (4.5% in 2015). Concerning hepatitis C, 36% of users who know the result of their last test say they have been cured and 15% of users who have been tested at least once say they are HCV carriers (Cadet-Tairou *et al.* 2020).

According to the RECAP 2019 survey (see T5. Sources), the percentage of lifetime injectors at CSAPAs who know their HIV and HCV status is up compared to 2018: 62.6% vs 60.4% and 64.6% vs 62.6% respectively. The reported prevalence among lifetime injecting drug user corresponds to 7.1% for HIV (6.9% in 2018) and 42.6% for HCV (44.6 % in 2018).

These reported data are likely to underestimate these seroprevalences, especially for HCV.

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 and 2020 HHR workbook).

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, 2019a).

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.

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. 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 co-morbidity (suggested title: Other drug-related health harms)

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 du 9 août 2004 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). 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](#)]. The standard specifies the objectives of harm reduction activities:

- Preventing severe, acute or chronic infections, especially those related to the use of shared injection equipment
- Preventing acute intoxication, including fatal overdoses from drug use
- Preventing and managing acute and related psychiatric disorders
- Referring drug users to emergency services, general care, specialist care and social services
- To improve their physical and mental health and their social integration

The law [no. 2016-41 of 26 January 2016 on health system reform](#) mentions in its article 41 that "*The professional acting in accordance with his or her harm reduction mission benefits, as such, from the protection mentioned in article 122-4 of the French penal code*".

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 T.1.1.1 of the 2018 Policy workbook for the main lines of this plan)

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 sections T 1.1.6 et T 3.1 of the 2020 Policy workbook)

The National health directorate published a guide to harm reduction tools for professionals in 2020 (Direction générale de la santé 2020).

Infection control

The infection prevention strategy includes dissemination of information, access to prevention materials, access to screening and treatment. The regulations on access to prevention equipment have gradually developed since 1987 (see T1.5.3).

Access to screening and treatment for hepatitis C is part of the prevention policy under the 2018-2022 French national health strategy, one of the measures of which aims to intensify prevention and screening actions for the most at-risk groups in order to contribute to the elimination of the hepatitis C virus in France by 2025. To achieve this objective, 3 main actions have been implemented:

- increased access to hepatitis C treatment by opening up to new prescribing doctors by promoting city-hospital networks;
- reinforcing community-based screening by using rapid diagnostic tests (RDT) in a combined approach to HIV, HCV and HBV;
- reinforcing prevention by means of innovative "outreach" actions to reach priority groups who are at a distance from the health system (Direction générale de la santé 2018).

Various measures have been put in place since 2016 to promote access to testing and treatment. Access to direct-acting antiretroviral drugs (DAAs) was extended to drug users in 2016, before universal access was introduced in 2017. Universal access has been accompanied by changes in the way treatment is initiated, with multidisciplinary consultation meetings limited to complex cases. The prescription by any doctor of two DAAs (Marivet®, Eplusa®) has been possible since May 2019. This measure was accompanied by the provision of a memo from the National Authority for Health on simplified management of hepatitis C in adults (HAS 2019a, b). In theory, these measures allow users to access all stages of care at the CSAPA level: prevention, screening, treatment, which in particular optimises the time between screening and treatment.

Regarding HIV, 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).

Preventing acute poisoning

In France the majority of overdose deaths are due to opioids. 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 (Ministère des Solidarités et de la Santé 2019).

- 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

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 T.1.4.9 of the 2020 'Treatment' workbook).

National coverage of medical-social harm reduction systems

In 2019, medico-social harm reduction facilities (CAARUD and CSAPA) covered the majority of the French territory: 5 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). Created in 2011, the remote syringe exchange programme 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 broadened 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 2019, 148 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 2019 represent approximately €64 million. The harm reduction actions carried out by the facilities mobilised a little over 950 FTE (full-time equivalents) in 2019, of which 74 jobs were filled on a voluntary basis. Nearly half of the number of staff of these organisations (44% of FTEs) are prevention educators and workers. The positions occupied by nursing staff and management are in second place for facilities in metropolitan 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 2019, the annual CAARUD new outpatient admissions were estimated at around 92 000 individuals, and a little more than 5 000 of them were seen in structures located in the overseas territories. Almost 53 000 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 seen in 2019, there were almost 22,000 people received in the fixed premises and mobile units, i.e. just under a third of the people seen in these two types of reception. The share of women is in the minority, with women accounting for approximately 30% of those monitored in these two settings.

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 (28% of actions carried out) and responding to the most basic needs (basic hygiene) corresponding to 12% of total actions. Actions relating to care and access to services are observed to a relatively lesser extent (7% 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 2019, the procedures least practised are those relating to access to and search for training and employment, and those relating to job retention and training (0.7%).

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). More than 4 out of 10 structures have self-help and self-support groups (Palle à paraître).

Although harm reduction measures constitute one of their missions, the actions of the CSAPA in this field can only be very partially quantified.

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.*

Harm reduction

The prevention measures used in France are of various types.

a) *Infectious diseases testing*

The testing system is particularly based on 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](#)], numbering 317 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. For an initial assessment of the activity of the CeGIDDs, see T.5.3 of the 2020 HHR WB.

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%.

HIV and HCV rapid diagnostic tests (RDT) are an additional screening tool. [Law n°2016-41 of 26 January 2016](#) on health system reform extends the practice of RDTs, beyond just healthcare professionals, to staff from prevention structures or associations who have 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.

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 (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 12.9 million syringes are estimated to have been distributed or sold to drug users in France in 2017, 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. In 2019, CAARUDs contribution to the provision of harm reduction material is estimated at 8.25 million syringes (see table below).

Table: Distribution of sterile prevention material by the CAARUD network in 2018 and 2019*

Injection equipment	All of France 2018	All of France 2019
Single syringes	5 508 411	5 570 063
Syringes in kits: automatic distribution machines	369 414	386 084
Syringes in kits: teams	952 176	998 654
Syringes in kits: pharmacy network	1 235 192	1 291 528
Total number of syringes distributed	8 065 193	8 246 329
sterile mixing containers	3 573 626	2 761 099
Sterile filters	1 547 972	2 112 749
Water (5-ml vials)	3 031 886	2 768 418
Alcohol pads	3 016 010	3 050 734
Total number of kits (automatic distribution machines, teams, pharmacy network)	1 278 391	1 338 133
Snorting equipment		
Small paper pads "roule ta paille"	607 950	649 192
Normal saline solution	220 481	292 605
Other snorting equipment	36 545	60 279
Inhalation equipment		
Measures	251 783	313 504
Tips	274 666	340 475
Crack filters	468 546	310 788
Inhalation kits	49 234	51 683
STI prevention material		
Male condoms	733 134	796 075
Female condoms	26 714	28 648
Lubricant gel	297 747	306 964
Other prevention materials		
Alcohol breath tests	68 429	95 282
Brochures, flyers (pharmacy network)	43 827	45 420
Brochures, flyers (caarud teams)	162 795	153 151
SEP (Syringe Exchange Programme) and DASRI (waste from care activities with infectious risk) activities		
Tokens (pharmacies)	13 128	14 252
Tokens (CAARUD teams)	47 503	59 100
Used syringes recovered by CAARUD teams	4 147 373	4 423 295
Syringes recovered via collectors	14 015 018	16 444 890

* 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 2018-2019 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 kits¹ 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).

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.

¹ 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.

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. In October 2015, Naloxone for nasal use has been exempted from list I of poisonous substance [[Arrêté du 13 octobre 2015 modifiant l'arrêté du 22 février 1990 portant exonération à la réglementation des substances vénéneuses destinées à la médecine humaine](#)]. Consequently, dispensing does not require a medical prescription; however, it is still a medication only available in pharmacies.

Nalscue® from the Indivior laboratory (naloxone 0.9 mg/0.1ml), initially made available under a temporary authorisation for use in July 2016 ([Order of 26 July 2016 amending the order of 17 December 2004 establishing the list provided for in Article L. 5126-4 of the Public Health Code](#)) and whose marketing authorisation (MA) came into force in January 2018, has not been marketed in France since November 2020. The drug was reimbursed at a rate of 65% on prescription. The kits were available at health establishments, CSAPAs and CAARUDs, but not at pharmacies.

The wide distribution of ready-to-use naloxone is one of the five objectives of the 2019-2022 roadmap "Preventing and responding to opioid overdoses" of the French Ministry of Social Affairs and Health (Ministère des Solidarités et de la Santé 2019).

Currently one speciality is marketed in France: Prenoxad® from the Ethypharm laboratory. Since June 2019, intramuscular naloxone kits (0.91 mg/ml) 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.

More ready-to-use Naloxone nasal spray kits should be available soon. 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. It is expected to be marketed in France by the end of 2021. It will be available at health establishments, CSAPAs, CAARUDs and at pharmacies.

The Ministry of Social Affairs and Health published several information documents on naloxone for professionals and the public in July 2020:

https://solidarites-sante.gouv.fr/IMG/pdf/fiche_memo_pro_naloxone_22fev2021.pdf ;
https://solidarites-sante.gouv.fr/IMG/pdf/fiche_memo_public_naloxone_22fev2021.pdf ;
https://solidarites-sante.gouv.fr/IMG/pdf/flyer_naloxone.pdf

In total, between 2016 and 2019, 21 050 naloxone kits were delivered (18 409 Nalscuc® 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.

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](#)] describe 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. It was modified by the order of 15 July 2019 [[Order amending the order of 22 March 2016 approving the national specifications relating to the experimentation of supervised harm reduction centres](#)] which, among other things, makes way for other modes of consumption, including inhalation.

Two DCRs have been opened in France as part of the experiment. The DCR in Paris [[Order of 25 March 2016 designating the Gaia CAARUD](#)] opened on 17 October 2016 and the Strasbourg DCR opened on 7 November 2016 [[Order of 25 March 2016 designating the Ithaque CAARUD](#)] (see 2020 HHR workbook).

The report on the evaluation of DCRs in France, provided for in article 43 of the law on health system reform and coordinated by INSERM, was published in May 2021 (INSERM 2021).

The report is based on 3 studies:

- The COSINUS study (Cohort for the assessment of injection rooms/inhalation rooms for drug users): follow-up of a cohort of 665 drug users recruited in Paris and Strasbourg and also in Bordeaux and Marseille, where DCRs do not exist.
- The COSINUS Eco study: economic evaluation of DCRs based on data from the COSINUS study and from the literature.
- A sociological study: Socio-anthropological survey of 160 stakeholders (local residents, cleaners and security officers, police officers, health and harm reduction professionals, users, politicians) on the impact of DCRs on public peace and its social acceptability.

The results of the COSINUS study show a positive impact of DCRs on health: they contribute to a reduction in risky practices thus lowering the risk of HIV and HCV transmission, but also in the risk of non-fatal overdose, visits to emergency services and complications at the point of injection. In terms of security, there has also been a reduction in crime in the vicinity of the DCR. However, DCR users had less access to primary care than non-DCR users. The authors believe that this could be explained by the fact that users who frequent DCRs are less likely to have social security cover or that they find in the DCRs some of the medical help they would have sought from a town doctor.

According to the results of the COSINUS Eco study, DCRs are cost-effective and could be improved if they were integrated into existing structures such as CAARUDs.

The sociological study reports "a diversity of experiences and perceptions of the DCRs", as well as a decrease in the traces of consumption in the vicinity of the DCR, with a significant decrease (by a factor of 3) in the number of syringes collected.

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 2021 Prison workbook.

g) Hepatitis B vaccination and campaigns targeted at PWID

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

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

h) Infectious diseases treatment and care

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

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

In 2020, the *Fédération Addiction* NGO took over the management of the network built by *Médecins du Monde*, formerly called the XBT mission, which is based primarily on thin layer chromatography. Alongside this network, other structures have joined the Galileo collective, which includes other practices, such as infrared. Meetings at national and local level were held several times in 2020 and 2021 in order to progressively develop shared frameworks for action and articulation between the different schemes. The aim is to help professionals choose, or direct them to, the most appropriate analysis tool for the situation.

In relation to these initiatives, the OFDT places the SINTES system in a supportive position, where possible, for example, by helping local laboratories to establish benchmarks using the products it collects (as is the case with adulterated cannabis herb, see T.1.15 of the 2021 "markets and crime" workbook), or by trying to raise awareness of the need to communicate important information within the framework of the French EWS.

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)

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>.

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) (G erome 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

There are currently three sources used to estimate direct drug-related deaths (DRD) in France: a general mortality registry and two specific registers.

The National registry of causes of death

The census of causes of death has existed in France since 1968 and is carried out by the Epidemiology Centre on Medical Causes of Death (CépiDc) of the National Institute for Health and Medical Research (INSERM). Death certification is mandatory in France. The death certificate, drawn up by the doctor who declared the death, includes a nominative administrative section and an anonymous medical section which mentions the cause of death. Since 2018, an additional medical component has been introduced. This section is completed,

where applicable, by the doctor who carried out the medical or scientific investigation into the cause of death or the forensic autopsy. The CépiDC produces annual statistics on causes of death based on the medical sections of death certificates. The coding of causes of death is based on the 10th revision of the International Classification of Diseases (ICD10).

Due to the infrequent use of the T code in France, direct drug-related deaths (DRD) are extracted from this registry by using an adaptation of the EMCDDA B selection: only codes X42, X62, Y12, F11, F12, F14, F15, F16 and F19 are retained.

The registry has national coverage and ensures that data are produced according to an internationally standardised procedure. However, there is a time lag in their availability: data for year N are only available in year N+2 at the earliest. In addition, there is an underestimation of DRDs. There are several reasons for this, including the fact that the results of forensic investigations are not always transmitted to the CépiDC, which does not allow the temporary code "causes unknown or ill-defined" initially assigned to them to be changed. The introduction of the complementary medical section transmitted directly to the CépiDC by the doctor who carried out the investigations should make it possible to improve the quality of the data, if it is indeed used to remedy this in part. Conversely, there may be false positives. Indeed, deaths by morphine overdose occurring in persons over 50 in a palliative care context, may appear as deaths of drug users. Finally, the registry is not very informative about the substances involved, the most frequently found codes being F19 and X142.

The Specific Registers

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)

Set up in 2002, this information system records deaths that have been the subject of a judicial investigation and of a request for toxicological analysis and/or autopsy. The analyses are carried out at the at the Public Prosecutor's request. The deaths are notified to the ANSM and to the CEIP- A in Grenoble by volunteer toxicologist analysts throughout France, the number of which varies according to the year.

Deaths meeting the EMCDDA definition of direct drug-related deaths are included in the survey, but not deaths by suicide. The investigation aims to describe the circumstances in which the body was found, the stage of abuse at the time of death and the results of the autopsy, as well as to identify and quantify the substances involved by means of blood tests. The DRAMES register is not exhaustive.

DTA: Analgesia-poisoning deaths

Network of the Regional Abuse and Dependence Monitoring Centres (CEIP-A) and French 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. The DTA register is not exhaustive.

The cases included in the DTA register (apart from those involving salicylic acid and paracetamol) added to those of DRAMES correspond to the deaths of the EMCDDA B selection.

The three sources used to describe the DRDs each have their limitations but are complementary: the CépiDC data make it possible to analyse the developments in the number of deaths, while the DRAMES and DTA data provide information on the distribution of deaths by substance.

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).

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 : Système d'information sur l'accessibilité au matériel officinal d'injection et à la substitution

Groupe pour la réalisation et l'élaboration d'études statistiques (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 2003-60 du 10 février 2003 relative à la mise en œuvre du nouveau dispositif de notification anonymisée des maladies infectieuses à déclaration obligatoire](#)), 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.

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*.

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).

In 2019, 2 735 fully completed questionnaires were included in the analysis (compared to 3 129 in 2015 and 2 905 in 2012). Between 1 and 161 questionnaires per CAARUD (20 on average) are included in the database. The data were adjusted according to the weight of the annual active files of each structure in the national active file of CAARUDs in 2018 (i.e., 65 602 individuals received at the premises and mobile units).

Mortality cohort study among drug users

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

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

RECAP: Common Data Collection on Addictions and Treatments

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

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

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

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

French Monitoring Centre for Drugs and Drug Addiction (OFDT)

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

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

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