European Monitoring Centre for Drugs and Drug Addiction

ecdc EUROPEAN CENTRE FOR DISEASE PREVENTION AND CONTROL

MEETING REPORT

3rd MEETING ON DETECTING AND RESPONDING TO OUTBREAKS OF HIV AMONG PEOPLE WHO INJECT DRUGS: 18 NOVEMBER 2013, BUCHAREST

Background

HIV incidence among people who inject drugs (PWID) has been steadily decreasing in Europe since 2000. However, a risk assessment conducted in EU/EEA countries in November 2011 by the European Centre for Disease Prevention and Control (ECDC) and the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) documented a significant increase in newly detected HIV cases among PWID in Greece and Romania[1]. The risk assessment concluded that there was a temporal association between low levels or reduction of provision of prevention services in these two countries and the increase in HIV transmission among PWID. It recommended an increased focus on prevention measures, such as needle and syringe programmes (NSP) and opioid substitution treatment (OST), and further epidemiological investigation to improve understanding and prevent further outbreaks.

A second updated risk assessment was conducted in 2013. Analysis of the most recent HIV surveillance, prevalence and response data indicates that several additional countries report increased HIV diagnoses or prevalence among PWID or may be at risk of increased HIV transmission among PWID. This is of concern, both because effective prevention measures exist and because HIV transmission can spread very rapidly among injecting populations.

In order to share best practice in monitoring and responding to the risk of HIV among PWID, ECDC and EMCDDA organised two expert meetings in 2012 in Tallinn, Estonia and Lisbon, Portugal. Following the updated EU risk assessment, a third joint expert meeting was held on 18 November 2013 in Bucharest, Romania (see Agenda in Annex 1). The expert meeting in Bucharest was attended by national HIV surveillance and prevention and drug-related infectious disease contacts from Bulgaria, Cyprus, Greece, Hungary, Malta, Romania and Slovakia, external experts from Finland, Sweden and the United Kingdom, and technical staff from ECDC and EMCDDA (see List of participants in Annex 2). It was followed by a roundtable meeting on 19 November 2013, which focused on the situation in Romania. This report summarises the key points from the third expert meeting presentations and discussions.

Session 1: Introduction and context

Professor Adrian Streinu-Cercel (National Institute for Infectious Diseases) and Sorin Oprea (National Antidrug Agency) opened the meeting and welcomed participants. Following introductions, Otilia Sfetcu (ECDC) outlined the purpose of the meeting, which was to:

[1] Joint ECDC and EMCDDA rapid risk assessment: HIV in injecting drug users in the EU/EEA, following a reported increase of cases in Greece and Romania. (2012).

- Review the current epidemiological situation with respect to HIV among PWID.
- Provide a platform for information exchange between countries and invited experts to support the response to the current HIV outbreaks in Greece and Romania and prevent the acceleration of HIV transmission among PWID in other countries identified at risk.
- Share evidence and experience of effective prevention practice.
- Strengthen country capacity to monitor and prevent further HIV infections in this population.
- Discuss the impact of the economic crisis on national responses to HIV among PWID and the potential for European Union Structural Funds to address funding gaps.

Otilia Sfetcu (ECDC) and Dagmar Hedrich (EMCDDA) then presented an overview of the main findings from the updated regional risk assessment[2]. The 2013 risk assessment, which reviewed data for 30 EU/EEA countries and Turkey for 2010-2012, used the same indicators as the 2011 assessment:

- Reported HIV diagnoses among PWID.
- HIV prevalence.
- HCV prevalence.
- Other injecting risk increase e.g. increase in injecting drug use, market changes, new substances.
- Proportion of opiate users receiving OST.
- Number of syringes per PWID per year.
- Changes in prevention funding.

Data sources included routine reporting (Tessy, Fonte/Statistical Bulletin 2013) and country consultation in May-June 2013. Data on HIV diagnoses was available for all countries; 18 countries had data on national HIV prevalence among PWID; 20 had data on OST coverage; and 13 on NSP coverage.

The assessment found that 25 countries have stable or declining rates of newly diagnosed HIV infections among PWID. Trends in HIV transmission among PWID are unclear in Austria, Bulgaria, Estonia and Latvia. However, Greece and Romania have experienced significant increases in HIV case reports among PWID (see table below). The rate per 100,000 in this population in Romania increased 30-fold from 0.04 in 2010 to 1.2 in 2012; the rate in Greece increased 20-fold from 0.2 to 4.6. In 2010, Greece and Romania accounted for 2.2% of newly diagnosed cases of HIV among PWID in the EU/EEA; in 2012 they accounted for 27.2% of new cases in this population (see graph below).

[2] Subsequent to the meeting, the results of this risk assessment were published: Hedrich et al 2013, available at: http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=20648

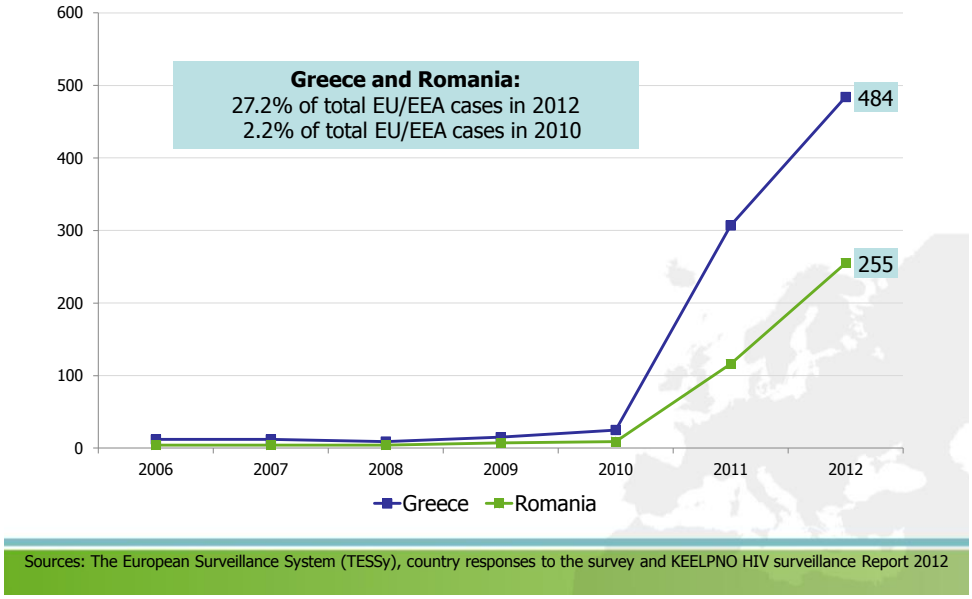
Newly diagnosed HIV infections among PWID, 2010-2012

2012
Rates per 100 000 between 1.0 - 5.4 in 5 countries

	HIV IDU case reports			Rate per 100 000 population		
	2010	2011	2012	2010	2011	2012
Estonia	62	69	72	4.63	5.15	5.37
Latvia	86	90	94	3.83	4.34	4.6
Greece	25	307	484	0.22	2.71	4.29
Lithuania	107	86	62	3.21	2.82	2.06
Romania	9	116	255	0.04	0.54	1.19
Iceland	9	12	3	2.83	3.77	0.94
Luxembourg	1	0	4	0.2	0	0.76
Bulgaria	56	63	40	0.74	0.85	0.55
Portugal	181	90	56	1.73	0.87	0.54
Austria	30	37	38	0.36	0.44	0.45
Spain	228	202	166	0.69	0.61	0.44
Italy	251	174	208	0.43	0.29	0.34
Ireland	22	16	13	0.49	0.35	0.28
Norway	11	10	11	0.23	0.2	0.22
Denmark	8	10	11	0.14	0.18	0.2
United Kingdom	148	131	111	0.24	0.21	0.18
Sweden	23	13	16	0.25	0.14	0.17
Finland	8	8	7	0.15	0.15	0.13
France	124	116	76	0.19	0.18	0.12
Poland	41	65	42	0.11	0.17	0.11
Germany	93	90	81	0.11	0.11	0.1
Czech Republic	5	9	6	0.05	0.09	0.06
Slovenia	0	0	1	0	0	0.05
Netherlands	6	5	7	0.04	0.03	0.04
Belgium	15	16	4	0.14	0.15	0.04
Slovakia	2	1	1	0.04	0.02	0.02
Cyprus	0	0	0	0	0	0
Hungary	0	0	0	0	0	0
Malta	0	0	0	0	0	0
Liechtenstein						
Total EU+EEA	**1551**	**1736**	**1869**	**0.32**	**0.35**	**0.37**
Croatia	2	3	1	0.05	0.07	0.02
Turkey	0	5	6	0	0.01	0.01

Sources: The European Surveillance System (TESSy), country responses to the survey

New HIV diagnoses among PWID in Greece and Romania, 2004-2012



Sources: The European Surveillance System (TESSy), country responses to the survey and KEELPNO HIV surveillance Report 2012

Other key risk assessment findings included:

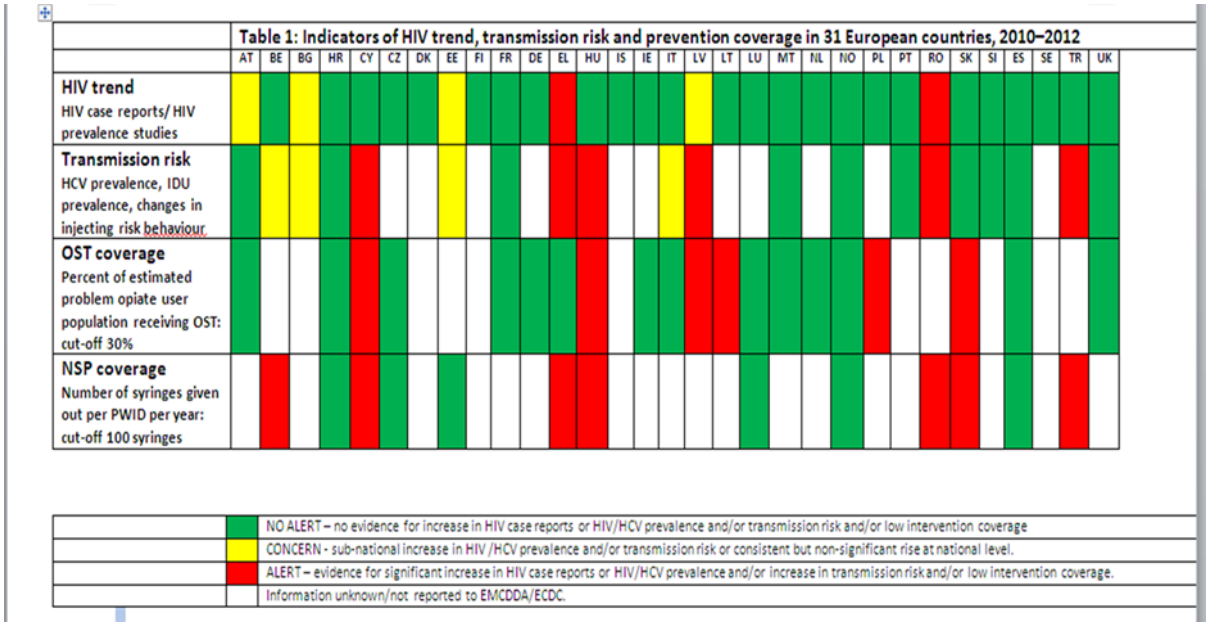
- Injecting risk – Increased injecting of stimulants was reported in Hungary and Romania; increased HCV prevalence or HVC prevalence above 50% among PWID was reported in Belgium (Flemish community), Bulgaria (Sofia), Cyprus, Estonia (Narva), Greece, Italy, Latvia, Romania (Bucharest), and Turkey.

- Prevention coverage – The proportion of problem opiate users in OST was at or below 20% in Cyprus, Hungary, Latvia, Lithuania, Poland and Slovakia; NSP coverage was below 100/PWID/year in Belgium, Cyprus, Greece, Hungary, Romania and Slovakia.

- Funding – 12 countries reported that funding for harm reduction for PWID was insufficient including Croatia, Cyprus, Estonia, Greece, Hungary, Latvia, Lithuania, Romania and Sweden; Austria and France highlighted insufficient responses in prisons and Germany insufficient NSP coverage in rural areas.

The table below provides a summary of the risk assessment findings, categorised according to the degree of risk. This highlights countries where there is potential for increased HIV transmission, based on HIV trends, factors increasing the risk of HIV transmission, and coverage with prevention interventions.

Finally, the risk assessment also highlights the need to monitor changes in patterns of drug use, for example, increased stimulant injecting, and the implications of these changes for HIV prevention, in particular for scale up of NSP, and for drug treatment programmes.



For further detail and information about sources see Supplementary Table available from:
http://www.emcdda.europa.eu/publications/joint-publications/hiv-in-injecting-drug-users/update-2013/supplementary-table

Session 2: HIV among PWID: Country updates

This session, chaired by Professor Adrian Streinu-Cercel (National Institute for Infectious Diseases), included updates on the outbreaks in Greece and Romania and recent developments in Bulgaria, Cyprus, Hungary, Malta and Slovakia.

Anastasios Fotiou (Greek Reitox Focal point of the EMCDDA; Athens University Mental Health Research Institute) provided an update on the situation in Greece. Key points were as follows:

- Situation – In 2010, prior to the outbreak, PWID represented 15 of the 604 newly reported cases of HIV (2.5%). In 2011, this increased to 260 of 962 cases (27%) and in 2012 to 522 of 1,180 cases (44.2%). However, the number of newly diagnosed cases of HIV among PWID declined between comparable periods in 2012 and 2013 (see table below). HIV prevalence rates among PWID range

from 6.2% among those tested at low threshold centres in Athens to 17.4% in those tested in the first four rounds of the Aristotle programme between August 2012 and September 2013 also in Athens, but there is no evidence that prevalence has increased.

- Characteristics – Findings from routine diagnostic testing in 2012 found that HIV-positive PWID are mostly male (79.1%), concentrated in Athens (93.6%) and aged below 34 years (64.7%); 95% used opioids and 7% used cocaine. HCV co-infection is very high (96.7%), as is the proportion who report ever sharing injecting equipment (88.1%). Data from a range of sources suggests that use of methamphetamines is increasing.

- Progress and challenges in the prevention response – There is legal access to and free provision of injecting equipment and appreciation of the value of harm reduction is increasing. The number of syringes distributed in 2012 increased significantly compared with 2011, outreach services have expanded through active collaboration with NGOs, and the first safe infecting facility has recently been established in Athens. Despite progress, coverage remains inadequate relative to needs in Athens, for example, the number of syringes distributed/PWID/year was still only 53 in 2012. The availability of NSP outside Athens is limited and pharmacies are not actively involved in distribution of injecting equipment. Although access to injecting equipment is legal, the police may still confiscate syringes.

Epidemiological update

PWID in HIV+ notifications

National surveillance system (KEELPNO)

	2010	2011	2012	Jan-Aug. '13	Jan-Aug. '12
Number of **HIV cases**	**604**	**962** 59%[a]	**1180** 23%[a]	**615** -22%[a]	784
Number of **HIV+ PWID**	**15**	**260** 1600%[a]	**522** 100%[a]	**188** -45%[a]	341
%IDU	*2.5*	*27.0*	*44.2*	*30.6*	*43.5*

[a] Percentage change compared to previous year or to the respective period

Source: HIV Office-Hellenic CDCP (KEELPNO). Unpublished data

Comment: A high number (n=188) of HIV cases with IDU as a probable source of transmission reported in the first 8 months of 2013—smaller compared to the same period in 2012

- Progress and challenges with treatment interventions – Drug-free, OST, detoxification and low threshold services are available; OST is offered by the state accredited services (OKANA). There has been a significant scaling up of OST services in the last two years to the extent that OST is available for one in two problem opiate users. HIV-positive opiate users are given priority entry to OST. Drug-free slots are available. However, there is still a waiting time for entry into OST in Athens, reflecting high demand that the current level of services is unable to meet. GPs are not involved in provision of drug treatment.

- Progress and challenges with HIV testing – HIV testing is available and in principle is free of charge. There is 100% HIV testing coverage of PWID entering OST and drug-free treatment. The Aristotle programme has screened more than 3,000 PWID in Athens since August 2012. NGOs provide

community-based testing included to those without health insurance. However, there is no routine testing for people in drug treatment.

- Progress and challenges with HIV treatment – Treatment is available and in principle free of charge including to undocumented migrants. HIV-positive PWID are referred for ART and NGOs support those without health insurance to access treatment. However, adherence support is a weakness and there are still demand-side barriers to accessing treatment for example among undocumented migrants.

- Funding issues – Inadequate and inconsistent funding for prevention and treatment interventions and community-based HIV testing is a challenge. However, based on service data for 2012, expenditure on harm reduction and on OST has remained stable despite the financial crisis. The main impact has been seen in reductions in staff salaries. Further reductions in public spending threaten progress and the sustainability of existing harm reduction and OST services in 2014; interventions such as the Aristotle programme and NGO programmes are supported primarily by EU funding.

Adrian Streinu-Cercel (National Institute for Infectious Diseases) provided an overview of the specific challenges in Romania. Key points were as follows:

- HIV transmission through injecting drug use has increased significantly since 2010. The proportion of new HIV cases attributed to injecting drug use rose from 1% in 2007 to 3% in 2010, 18% in 2011 and 30.6% in 2012. The number of new HIV infections in PWID increased from 5 in 2010 to 102 in 2011 to 180 in 2012.

- HCV prevalence, an indicator of HIV transmission risk, among PWID is very high. Various studies have shown HCV prevalence rates ranging from 80% to 97% in HIV-positive PWID.

- There is also evidence of changing patterns of drug use, including increased injecting of stimulants or 'legal highs'[3] and as a result, more frequent injecting. This has implications for sharing of injecting equipment at a time when the availability of needles and syringes is decreasing. However, it is possible that the use of stimulants may reduce since these were made illegal in 2012.

- HIV among PWID in Romania appears to be caused by a specific sub-type of the virus, similar to that seen in Greece (CRF14_BG). Travel between the two countries may be a factor.

Other countries reported that there have been no significant developments since the 2013 updated risk assessment. Key points from country updates are summarised below.

Bulgaria:

- HIV trends – Between January and 14 November 2013, 179 new HIV cases were reported; 15.6% of these in PWID. In 2012, HIV prevalence among PWID in Sofia was 3.62%. Although overall there has been no increase in HIV in 2012 and 2013, HIV prevalence in PWID who are under the age of 25 is higher.
- Transmission risk – HCV prevalence among PWID has remained stable, at around 68%, in 2011 and 2012. There has been no change in the number of PWID or in injecting risk behaviour.

[3] These have subsequently been regulated and have not been legally available since 2011.

- Prevention coverage – 18.2% of problem opiate users are in OST; 45 syringes/PWID/year distributed (7.7 million kits have been distributed with Global Fund financing between 2004-2013).
- Funding – ART is free of charge and funded by the state and is provided to all who need treatment regardless of their health insurance status; methadone is procured by the state for public and private programmes additional funding has been provided for ART and OST in 2013 through the Global Fund grant. However, the Global Fund grant closes in 2014 and this will present a challenge.

Cyprus:

- HIV trends – In 2012, a total of 58 new HIV cases were reported; only one of these was in a PWID.
- Transmission risk – HCV prevalence among PWID has remained relatively stable between 2010 and 2012; more than 50% of PWID tested are positive for HCV; 36 of 46 HCV positive cases are foreign nationals from other EU countries or non-EU countries. Heroin use is declining and the proportion of heroin users who report that they have ever or currently share injecting equipment has decreased.
- Prevention coverage – In 2012, three new centres providing substitution treatment were established. The new National Action Plan 2013-2016 aims to strengthen harm reduction including distribution of free condoms and syringes. Other interventions include infectious diseases screening and HCV referral and treatment. There are no specific interventions targeting migrant PWID.

Hungary:

- HIV trends – The number of new cases of HIV were 162 in 2011, 219 in 2012 and 137 in 2013 (as of 1 June); one person with a foreign citizenship belonged in 2013 to the PWID group. The last national HIV/HCV/HBV prevalence study in PWID was done in 2011; a 3-year HIV/HVC/HBV diagnostic testing study was completed in June 2013.
- Transmission risk – Between 2009 and 2012, the proportion of PWID using heroin decreased from 56% to 17%, the proportion using amphetamines remained at around 40% but the proportion using other substances (e.g. pentedrone, MDPV) increased from 4% to 43%. Injecting other substance was the most prevalent among young PWIDs. In 2011 national HCV prevalence among PWID was 24%, but was higher among non-opioid users (30%) than among opioid users (18%) and HCV prevalence has increased significantly among non-opiod users. According to 2012 sub-national data, HCV prevalence, injecting frequency, reuse of syringes and sharing of injecting equipment are also higher in those using substances such as pentedrone, MDPV and 4-MEC than in opiate or amphetamine users.
- Prevention coverage – 20% of estimated heroin users were in OST in 2012; financing is limited and there is a waiting list of 1-6 months. In 2012 an estimated 74 syringes/PWID were distributed, 35% less than in 2011 when the figure was 114/PWID. Geographical coverage increased in 2012 but NSP with a high turnover had to limited the number of syringes distributed per contact and also opening hours; some programmes also had to close temporarily or permanently.
- Funding – Overall, state funding allocated for NSP shows a decrease in 2012-2014 compared to 2009-2011; one-off additional state grants were provided to the largest NSPs in 2012 and 2013. However, the local (district level) political environment is challenging for the biggest NSP in Budapest, also that programme is increasingly relying on non-state financial support.

Malta:

- HIV trends – There have been three new cases of HIV in PWID so far this year identified at a methadone dispensing centre; one an MSM and the other two a heterosexual couple; it is possible that HIV transmission in these cases was due to unsafe sex rather than to injecting drug use. Data is available on HCV prevalence among PWID but not on HIV prevalence; prior to 2013 Malta has had no cases of HIV among PWID.

- Transmission risk – There has been no change in the number of PWID, injecting behaviour or HCV prevalence. There are, however, concerns about a possible increase in cocaine use.
- Prevention coverage – No official figures for OST coverage are available for 2013, but it is expected that coverage will be similar to that in previous years i.e. around 50%. There are no NSP in Malta; needles and syringes are dispensed by health centres.
- Funding – The state health budget provides funding for HIV-related prevention services. However, limited financial and human resources are a challenge.

Slovakia:

- HIV trends – In 2012, one new HIV case acquired through injecting drug use was reported. HIV prevalence among PWID is estimated at 0.3%. Of all new HIV cases reported between 1985 and 2012, 2.8% were acquired through injecting drug use.
- Transmission risk – The number of PWID and opiate users has declined since 2002. There has been a shift from opiates to methamphetamines; those using methamphetamines are injecting less frequently. The decline in heroin use is attributed to a shortage of heroin, increasing age of drug users and a proactive approach to provision of drug-free treatment. Changes in patterns of drug use have implications for drug treatment programmes.
- Prevention coverage – NSP, drug-free treatment and OST are available free of charge; OST coverage is estimated at >30%; NSP coverage at <100/PWID/year. Syringes can also be bought at low cost from pharmacies.

Key discussion points included:

- Causes of the outbreak in Greece – In response to a question about whether there were specific factors that caused the outbreak, participants from Greece noted that this complex. However, rapid transmission following the introduction of HIV into the drug injecting population was exacerbated by high rates of sharing of injecting equipment and the impact of the economic crisis.

- HIV prevalence among PWID in Romania – Currently accurate national estimates of prevalence among PWID is not available in Romania. There are no accurate estimates of the denominator i.e. the total number of PWID or problem opiate users – or disaggregated estimates for Bucharest and the rest of the country. However, data from sources including the National Antidrug Agency, the 2012 BSS and NGOs suggests that HIV prevalence is between 23% and 53%, although these are based on potentially non-representative samples.

- The importance of understanding and monitoring local patterns of drug use and injecting behaviour – Participants noted, for example, that in some countries, e.g. Hungary, changes in drug use had contributed to increased frequency of injecting while in others, e.g. Slovakia, it has had the opposite effect. The shift to non-opiates is also reported to have resulted in less injecting in Estonia. Changes in the drug market and the legal context also influence patterns of drug use; it is possible that users will shift back to opiates if heroin becomes more available in countries where there has been a shortage and if non-opiates are made illegal. It is also important to recognise that some are using both opiates and non-opiates.

Session 3: Implementing HIV prevention among PWID

This session, chaired by Lucas Wiessing (EMCDDA), provided an opportunity to hear about how a better understanding of risk environments for HIV and HCV could make HIV prevention more effective, approaches to HIV prevention among PWID in Finland and Sweden, and the Greek experience of responding to the recent HIV outbreak.

In his presentation, Tim Rhodes (London School of Hygiene and Tropical Medicine) highlighted the need for better data to improve prediction and prevention of HIV outbreaks among PWID and for a combination of interventions to reduce HIV incidence among PWID.

He started by noting that assessment of risk tends to focus on individual biomedical and epidemiological factors, but could have greater value if it also considered social and environmental factors. Experience suggests that these contextual factors can play a role. For example, in Vancouver, Canada, changes in housing policy had an impact on HIV among PWID. Likewise, rapid economic change, removal of social safety nets, weak state structures, opening up of borders, growth in criminal networks and other factors created a situation conducive to risk in countries affected by the break-up of the former Soviet Union.

Also of particular relevance in Europe is the role played by the current economic crisis and the impact of austerity measures on risk. Experience in Greece suggests that the impact of the economic crisis on employment, health services and homelessness was a factor in the HIV outbreak among PWID in Athens. Other countries identified as being at potential risk of increased HIV transmission in this population group include those that have been forced to implement austerity measures. Monitoring these factors and measuring their impact is, however, complex.

He then presented the findings of modelling the impact of individual interventions and of a combination of interventions on HIV incidence among PWID. This shows that, even with very high coverage, NSP alone will not reduce HIV incidence by 50% over a 10-year timeframe. The greatest impact is likely to be achieved by a combination of NSP, OST and ART, even with lower coverage of each of these interventions (see chart below). OST is often the entry point to ART for PWID. In contexts where stimulants and other non-opiates are widely used, it will be critical to ensure that other drug treatment programmes are linked to HIV treatment.

In addition, provision of services alone is not enough if there is insufficient demand for services among those who need them. Qualitative research suggests that factors that can limit uptake of available services include: habitual delay; perception that having to wait to be seen is a manifestation of stigma; shame; fear of phlebotomy; limitation expectations; and lack of co-location.

Key recommendations for improving HIV prevention among PWID include:

- Increased investment in qualitative research and inclusion of wider contextual factors in risk assessments and responses.
- Introduce measures to make services more accessible including integration and co-location of services, and involvement of PWID in service delivery.
- Consider the potential influence on health and risk behaviour of employment, housing and other policies, and avoid ‘policy harm’.

Professor Angelos Hatzakis (Athens University Medical School) described how the Aristotle programme has used a ‘seek-test-treat retain’ intervention to decrease HIV transmission among PWID in Athens. The programme aimed to increase HIV screening of PWID, provide PWID with a package of prevention, treatment and care, and reduce the incidence of HIV in this population. It also aimed to improve prevalence and behavioural data and improve PWID links to and retention in care. Key aspects of the programme were as follows:

- Increasing the number of PWID who are tested for HIV was fundamental. To increase uptake of testing, the programme used Respondent Driven Sampling. The programme includes five rounds of recruitment between August 2012 and December 2013, with the aim of recruiting approximately 1,400 PWID in each round. Four rounds have been completed and the fifth round is in progress.

Non-random selection of PWID was used to identify 'seeds' representing a diversity of age, gender and ethnicity. Seeds recruited and referred a specific number of PWID from their networks for HIV testing. Financial incentives were used to encourage PWID to refer, to encourage those referred to come for testing and respond to the programme questionnaire and, from the second round onwards, to come for their test results. PWID could participate in more than one round but only once in each round.

- Using a modified version of the National HIV Behavioural Surveillance System IDU questionnaire enabled the programme to collect data on issues including sexual behaviour, drug and alcohol use, drug and alcohol treatment, HIV testing, health status, and food insecurity.

- Providing services at a central site was more effective and less expensive than outreach services. HIV testing and other services were provided at a site in central Athens staffed by ex-drug users, a doctor, psychologist, social workers, cultural mediators and an NGO volunteer.

The programme has shown impressive results. In the first four rounds it reached 3,007 PWID, 87% of the total estimated number of PWID in Athens. Of these, 523 (17.4%) were HIV positive. Of the 411 who were found to be HIV positive during the first three rounds, 53% were diagnosed by the programme. HIV prevalence remained stable across the four rounds, suggesting that incidence has not increased.

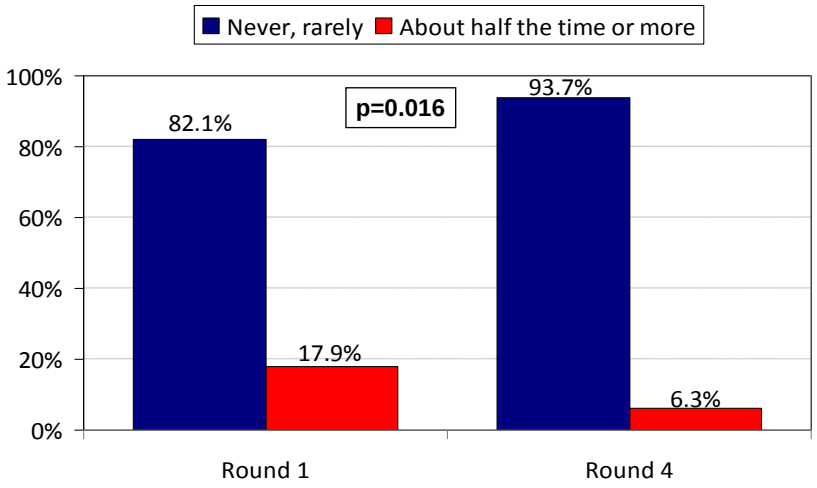
Data on risk behaviours also suggests that the programme, and increased HIV testing in particular, has resulted in a reduction in the frequency of injecting and of sharing syringes among both HIV-positive and HIV-negative PWID and in an increase in condom use among HIV-positive PWID. Specifically:

- The proportion of HIV-positive PWID who reported injecting at least once a day fell from 63.2% to 28.4% between the first and fourth rounds, while the proportion who reported injecting less than once a day increased from 36.8% to 71.6% in the same period.

- The proportion of HIV-negative PWID who reported injecting at least once a day fell from 47.2% to 22.7% between the first and fourth rounds, while the proportion who reported injecting less than once a day increased from 52.8% to 77.3% in the same period.

- The proportion of HIV-positive PWID who reported sharing syringes about half the time or more in the past 12 months fell from 17.9% to 6.3% between the first and fourth rounds, while the proportion reporting that they never or rarely shared in the past 12 months increased from 82.1% to 93.7% in the same period (see chart below).

HIV(+): Sharing syringes (in the past 12 months)



- The proportion of HIV-negative PWID who reported sharing syringes about half the time or more in the past 12 months fell from 9.9% to 2.4% between the first and fourth rounds, while the proportion reporting that they never or rarely shared in the past 12 months increased from 90.1% to 97.6% in the same period.

- The proportion of HIV-positive male PWID who reported using condoms always or usually yes in the past 12 months increased from 52.9% to 80.4% between the first and fourth rounds, while the proportion who reported using condoms never or usually no in the past 12 months fell from 47.1% to 19.6% in the same period.

- The proportion of HIV-positive PWID who had participated in a drug treatment programme in the past 12 months also increased from 28% to 45.7% and the proportion currently on OST also increased between rounds one and four.

The programme has also highlighted a number of issues and challenges. First, factors associated with increased risk of HIV infection include homelessness, cocaine as the main substance of use, injecting drug use at least daily, and sharing syringes 'always' or 'almost always'. Of these, homelessness was the most significant factor. Data on unemployment as a risk factor is currently being analysed.

Second, the importance of providing services for migrants. HIV prevalence was higher among migrant PWID than those of Greek origin. For example, prevalence was 16.6% in those of Greek origin, compared to those whose country of origin was Afghanistan or Iran (29.3%), elsewhere in Asia (25.4%) or the Middle East (18.7%) or in Eastern Europe (23.2%). Migrant PWID are enrolled, interviewed in their own language (the programme worked in eight languages), and provided with the same package of services. HIV-positive undocumented migrants are referred to an NGO for services.

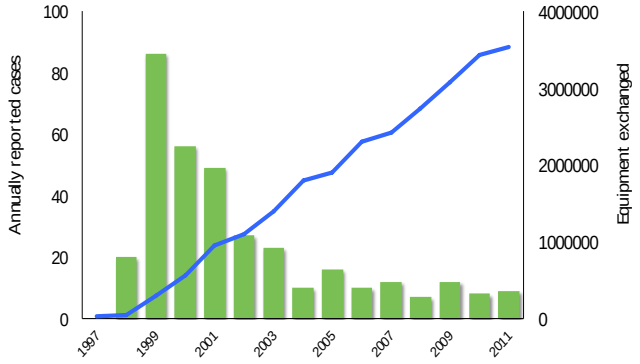
Third, linking HIV-positive PWID to ART has been a challenge, because treatment centres have limited capacity and are often reluctance to treat PWID.

Anne Ovaska (A-Clinic Foundation Tampere) focused on lessons from Finland's experience of dealing with an HIV outbreak in PWID in the late 1990s and the Finnish approach to provision of harm reduction services.

Finland has a 'two track' policy approach which includes both active criminal control of drug users and active harm reduction. Following a significant increase in drug use and drug-related harms in the late 1990s, including an HIV outbreak in capital area among PWID in 1998-1999, Finland rapidly introduced and expanded harm reduction, low threshold substitution and antiretroviral treatment for HIV positive PWID including a network of needle exchange services with peer work and outreach activities. These actions prevented a major epidemic and resulted in a sharp decline in new cases of HIV among PWID. The following graph shows the correlation between increased distribution of injecting equipment and reduced incidence of HIV infection.

A-Clinic Foundation

Correlation of service increase and annually reported cases of HIV infection



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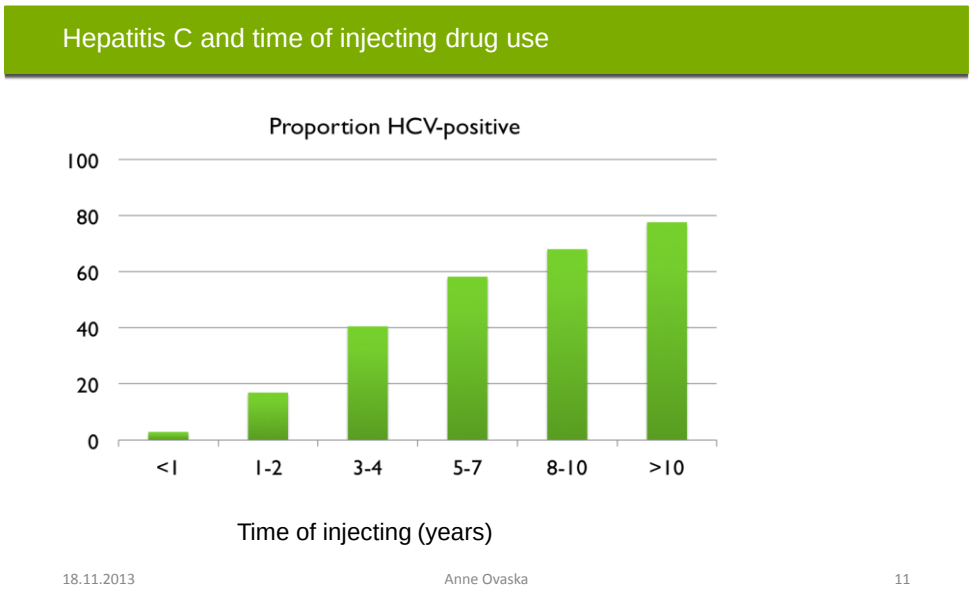
- There are an estimated 14,500-19,100 opioid (mostly buprenorphine) and/or amphetamine and tranquilizer users; these drugs are mostly injected drugs; poly-drug use is most common; most PWID are aged between 25 and 35.

- It has been estimated that Almost 60% of PWID are in contact with needle exchange services; as of 2011, there were 30 low threshold centres, funded by local municipalities, providing services to 11,432 clients. In 2011, 3.5 million needles and syringes were distributed, the equivalent of 309 per client. An additional 500,000 needles and syringes were sold through pharmacies. In 2000, 12 low threshold centres provided services to 4,800 clients including around 500,000 needles and syringes.

- The number of PWID in substitution treatment increased from 5 in 1997 to 2,400 in 2011.

- HCV prevalence among PWID has declined but there are still around 1,000 cases a year. HCV infection is associated with the length of time an individual has been injecting drugs (see graph below).



Key factors in successful control of the outbreak in Finland and subsequent low rates of HIV transmission among PWID include:

- Providing strong leadership taking rapid action and ensuring that roles and responsibilities are clear.
- Distributing sufficient quantities of needles and syringes.
- Making needles and syringes available through pharmacies.
- Providing anonymous and confidential services to PWID.
- Supporting frontline professionals and volunteers who provide services for PWID.
- Involving PWID in service delivery and allowing secondary exchange of syringes and needles.
- Providing antiretroviral treatment and low threshold OST for HIV positive PWID.

Martin Kåberg (Karolinksa University Hospital) provided a brief overview of the HIV situation among PWID in Sweden and the response to the HIV outbreak in PWID in 2007, and described the introduction of the first needle exchange programme (NEP) in Stockholm in April 2013. The main points were as follows:

- Sweden currently has approximately 6,200 people who have been diagnosed with HIV and who are in contact with the health system. Of these, 1,100 cases are associated with injecting drug use. Of the 1,806 HIV patients at the Karolinska University Hospital in Stockholm, route of infection was injecting drug use for 225 (12.5%).

- There are estimated to be around 30,000 problem drug users in Sweden, although accurate data is not available. Coverage with OST is thought to be high at 70% among those qualifying for OST (by policy, only those with documented heroin or opium use qualify for OST). The prevalence of HCV among PWID is high, at between 82% and 86%. There is potentially high risk of rapid spread of HIV in this population. However, coverage with NSP is low. Prior to 2006, when a law was passed to enable NSP implementation, services were only available in Lund and Malmo. Since 2006, NSP

have been established in Helsingborg and Kalmar and, in April 2013, in Stockholm. Pharmacies are not permitted to sell needles and syringes.

- Sweden experienced an outbreak of HIV among PWID in 2007. There were 71 new cases that year, compared with the average in previous years of 20 new cases. The response to this outbreak included: an extensive HIV testing programme; a baseline study, which found that 93% of PWID had shared needles, syringes or other equipment in the previous month; clear messages about sharing equipment; the introduction of 'unofficial' NSP; and the expansion of OST through methadone programmes. As a result of these measures, the incidence of HIV in PWID fell sharply.

Sweden has a zero tolerance approach to drugs and the introduction of NSP has been politically problematic. The recently established Stockholm NSP is therefore being implemented as a 4-year trial and has to operate within certain limitations. Clients must be aged 20 years or more, live in Stockholm, identify themselves and consent to be interviewed and to blood tests.

It provides health services for PWID, is staffed by a multidisciplinary team and links patients who need ART to the Karolinska University Hospital. Data has to be recorded about the number of needles and syringes distributed and the number returned; the NEP is expected to demonstrate that the majority are returned, which is problematic. However, needles and syringes can be given to clients who are on OST; NEPs are not allowed to do this in some parts of Sweden. To date, 860 people have been enrolled; the aim is to cover 3,000. Screening of 750 clients found that 10% had HIV, 82% HCV and 2% HBV infection.

Session 4: HIV prevention among PWID in the context of the economic crisis

This session, chaired by Anastasia Pharris (ECDC) and Tim Rhodes (London School of Hygiene and Tropical Medicine) discussed the effect of the economic crisis and of the withdrawal of Global Fund support on HIV prevention among PWID and possible alternative funding sources including European Union (EU) Structural Funds.

Anastasios Fotiou (Greek Reitox Focal point of the EMCDDA; Athens University Mental Health Research Institute) introduced his presentation by noting that discussion of the economic crisis and the HIV outbreaks in Greece and Romania has mostly focused on cuts in public funding and the effects of these on service provision. There has been less consideration of the impact of wider policy and socio-economic factors such as GDP growth rate, unemployment, poverty, unequal income distribution and social exclusion.

He then presented the findings of an on-going project, funded by ECDC, which aims to analyse the relationship between these wider contextual determinants and HIV epidemic trends in PWID in the EU/EEA countries. The study will be completed in early 2014. Preliminary analysis of available data from 2003-2012 for a range of variables suggests that there may be an association between GDP growth rate, poverty and income inequality (GINI and s80s20) and HIV outbreaks among PWID (see t below). The association is affected by the timeframe: increased income inequality appears to have a more immediate effect than economic recession (negative GDP growth rate). He concluded by noting that there are many gaps in the data and that further analysis is required to assess the pathways from recession and inequalities to HIV epidemics.

Table.
Results from preliminary analyses: Logistic regression for panel data (random effects); dependent variable: HIV outbreak (yes/no); period: 2003-2012; data from 30 countries; HIV outbreaks: GR, RO 2011-2012, and BG 2006-2012

	LAG 1						LAG 2					
	OR	95% CI Lower	95% CI Upper	p	No. of observ.	No. of countries	OR	95% CI Lower	95% CI Upper	p	No. of observ.	No. of countries
Bivariable analyses												
GDP growth	**0.78**	0.62	0.98	**0.031**	300	30	**0.66**	0.49	0.88	**0.004**	300	30
Poverty	**1.80**	1.16	2.78	**0.009**	259	30	**1.63**	1.09	2.42	**0.017**	253	30
s80s20	**3.13**	1.15	8.53	**0.025**	261	30	**3.07**	1.10	8.57	**0.032**	255	30
GINI	**1.43**	1.03	1.98	**0.033**	258	30	**1.40**	1.03	1.91	**0.033**	251	30
Multivariable analyses*												
GDP growth	0.84	0.66	1.07	0.152	259	30	**0.72**	0.53	0.98	**0.039**	253	30
Poverty	1.75	0.99	3.10	0.056			1.57	0.95	2.59	0.078		
GDP growth	0.81	0.65	1.01	0.067	261	30	**0.68**	0.50	0.92	**0.012**	255	30
s80s20	**2.95**	1.00	8.68	**0.050**			3.32	0.98	11.21	0.053		
GDP growth	0.80	0.64	1.00	0.053	258	30	**0.65**	0.48	0.86	**0.003**	251	30
GINI	**1.40**	1.01	1.95	**0.045**			1.49	1.00	2.22	0.053		

**Note.* Poverty, Gini and S80S20 were highly correlated (r>=0.9) and they were not included in the same model with GDP growth

Fidelie Kalambayi (Romanian Angel Appeal) discussed funding for harm reduction programmes in Romania and the impact of withdrawal of Global Fund support.

Between 2004 and 2010, the main funding for harm reduction interventions was from international sources, in particular the Global Fund, as well as UNODC and UNICEF. Global Fund support ended in 2010 and Romania has received the final disbursement from UNODC. Since 2010, external support has mainly been provided by the European Social Fund, European Agency for Health and Consumers and the Swiss Fund. Some domestic funding has also been provided by the National Antidrug Agency, Ministry of Labour, Ministry of Justice, Ministry of Health and Bucharest City Council. Despite this, there are significant challenges. The European Social Fund provides co-funding and it has been difficult to secure matching funds; funds available are not specifically for harm reduction. The economic crisis and the end of Global Fund support has affected NGOs providing harm reduction services. As a result, between 2010 and 2013: the number of NGOs providing outreach harm reduction services has decreased from 5 to 2; the number of penitentiaries providing NSP has decreased from 10 to 2; the number of syringes distributed has fallen from around 1.7 million in 2009 to less than 900,000 in 2011; and there is no funding available to support NGO distribution of available syringes in 2013. Additional funding is needed to maintain existing services and to scale up provision of harm reduction.

Tonka Varleva (HIV/AIDS Prevention and Control Programme) outlined the situation in Bulgaria. Global Fund support, which has funded NGOs to deliver a range of services for PWID, including drop-in centres, screening, mobile medical units, outreach and referral for ART, as well as funding OST, will end in 2014. Financial sustainability of NGO services and OST after 2014 will be a challenge. However, it is anticipated that municipalities will continue partially to support the nine drop-in centres and associated services. Additional funds will also be required.

Yoline Kuipers (EuroHealthNet) provided an overview of EU Structural Funds and the potential to finance HIV prevention programmes through this mechanism. Key points were as follows:

- Structural Funds are the financial mechanism to support implementation of the EU's Cohesion Policy, which aims to reduce economic, social and other disparities in Europe. Romania received €19.7 billion in Structural Funds from the EU during 2007-2013.

- The budget for Structural Funds for 2014-2020 is €325 billion, more than one third of the total EU budget. Social inclusion and poverty is one of the 11 thematic areas for 2014-2020, which are intended to achieve the European 2020 vision. Approximately 50% of the total Structural Funds budget is allocated for less developed regions.

- Structural Funds are available through five funding programmes. The two most relevant to health and HIV programmes are the European Regional Development Fund (ERDF), which finances 'hard projects' such as infrastructure, and the European Social Fund (ESF), which finances 'soft projects', such as social inclusion. Countries apply for funds through a Managing Authority; countries can also identify priorities for funding.

- During 2007-2013 Structural Funds have been used to finance health and HIV programmes including support for HIV prevention campaigns and training in Lithuania, HIV research in Poland, malaria control in Greece and health infrastructure, including sexual health clinics, in Latvia.

She noted that the process for accessing Structural Funds is complex. However, the chances of success can be increased by: developing an understanding of the process and country priorities; working with the Managing Authority and building partnerships with organisations that have experience with Structural Funds; developing proposals that are consistent with the EU 2020 vision and thematic areas. She also noted that it is essential to engage in national processes that will determine country priorities. More information is available in the EuroHealthNet report on Health Equity and Regional Development in the EU[4]: Applying EU Structural Funds, which is available at www.health-inequalities.eu. Practical guidance is also available in the Structural Funds Online Guidance Tool, which can be accessed at www.fundsforhealth.eu.

Session 5: Conclusions and the way forward

Andrew Amato (ECDC) and Dagmar Hedrich (EMCDDA) chaired the final session and briefly summarised the meeting.

Despite the challenges faced by many countries in the region, not least the effects of the economic crisis, there has been significant progress. Monitoring has improved and many countries have succeeded in maintaining or scaling up evidence-based interventions. Greece has shown what can be done to respond to an outbreak in a short timeframe, even under difficult economic conditions.

However, the risk assessment has identified the need to scale up HIV screening and coverage with a combination of interventions in a number of countries. In addition, more needs to be done to improve prevalence data and understanding of the role of stimulants in driving HIV transmission. Continued vigilance will be required to monitor patterns of drug use and injecting behaviour. Greater emphasis is needed on issues such as HCV and drug treatment for non-opiate users. At the same time, funding is a concern in many countries. International funding is not a long-term solution. A stronger case needs to be made for domestic investment in effective HIV prevention among PWID.

The final session also considered the role of ECDC and EMCDDA in providing support to countries. Participants noted that ECDC and EMCDDA risk assessments and technical support to individual countries to address HIV outbreaks have been critical. ECDC and EMCDDA guidelines have also played an important role in influencing national policy and informing practice.

[4] http://www.equityaction-project.eu/regions/structural-funds/

Areas raised by participants regarding where ECDC and EMCDDA could provide further support included:

- Advice to countries regarding access to EU funds;
- Advice to plan for withdrawal of Global Fund support and to assist to develop an investment case;
- Advocate with EU institutions and national governments;
- Ensure knowledge, experience and best practice is shared and communicated;
- Promote cross-country projects and study exchange visits; and
- Funding additional research, including qualitative research and joint research on treatment interventions for stimulant users in affected countries.

Otilia Sfetcu (ECDC) closed the meeting by thanking the National Institute for Infectious Diseases for hosting the meeting and thanking all the participants for their contributions.

Annex 1: Agenda

Session 1 Introduction and background

08:30 – 08:50 Welcome and introductions (Adrian Streinu-Cercel, Sorin Oprea)

08:50 – 09:00 Background and meeting objectives (Andrew Amato)

09:00 – 09:20 Risk assessment on HIV among PWID in the EU/EEA 2013 (Dagmar Hedrich, Otilia Sfetcu)

Session 2 Situation of HIV among PWID: Country updates

09:20 – 09:50 Ongoing outbreaks of HIV among PWID

Greece (Anastasios Fotiou)

Romania (Adrian Streinu-Cercel)

09:50 – 10:20 Additional country updates: Bulgaria, Cyprus, Hungary, Malta, Slovakia

10:20 – 10:30 Conclusions and summary

Session 3 Implementing HIV prevention among PWID

11:00 – 11:15 Risk environment for HIV and HCV (Tim Rhodes)

11:15 – 11:30 Responding to an HIV outbreak: the Aristotle programme (Angelos Hatzakis)

11:30 – 11:45 Model-driven prevention practice: the Finnish experience (Anne Ovaska)

11:45 – 12:00 Data-driven approach to needle exchange in a difficult political environment (Martin Kåberg)

12:00 – 12:30 Discussion

Session 4 Preventing HIV among PWID: The economic crisis

13:30 – 13:45 Effects of the economic crisis on HIV among PWID in the EU/EEA (Anastasios Fotiou)

13:45 – 14:00 Discontinuation of Global Fund support: impact and funding alternatives – Romania (Fidelie Kalambayi) and Bulgaria (Asena Mateeva and Violeta Bogdanova)

14:00 – 14:20 Structural Funds and HIV prevention (Yoline Kuipers)

14:20 – 14:45 Discussion

Session 5 National and EU response

15:15 – 16:15 Two years of increasing in HIV among PWID: appraisal of national and EU-level response and suggestions for moving forward

Annex 2: List of participants

	Name	Country
1	Anastasios Fotiou	Greece
2	Prof Angelos Hatzakis	Greece
3	Martin Kåberg	Sweden
4	Anne Ovaska	Finland
5	Yoline Kuipers	EuroHealthNet
6	Anastasia Pharris	ECDC
7	Otilia Sfetcu	ECDC
8	Dagmar Hedrich	EMCDDA
9	Lucas Wiessing	EMCDDA
10	Prof Adrian Streinu-Cercel	Romania
11	Mariana Mardarescu	Romania
12	Adrian Abagiu	Romania
13	Andrei Botescu	Romania
14	Marian Ursan	Romania
15	Mioara Predescu	Romania
16	Silvia Asandi	Romania
17	Fidelie Kalambayi	Romania
18	Sorin Oprea	Romania
19	Violeta Bogdanova	Bulgaria
20	Tonka Varleva	Bulgaria
21	Asena Mateeva	Bulgaria
22	Anna Tarjan	Hungary
23	Roland Gyekiss	Hungary
24	Tim Rhodes	UK
25	Neoklis Georgiades	Cyprus
26	Joseph Tonna	Malta
27	Reuben Cutajar	Malta
28	Peter Truska	Slovakia
29	Zuzana Alexandercikova	Slovakia
30	Kathy Attawell	ECDC consultant